



**Department  
of Health**

## **Ambulatory Patient Groups (APGs) Medicaid Fee-for-Service Provider Manual Policy and Billing Guidelines**



Table of Contents:

- 1 Background and Introduction to APGs..... 3
  - 1.1 Purpose ..... 3
  - 1.2 Overview of APG Reimbursement Methodology ..... 3
  - 1.3 APG Software ..... 4
  - 1.4 APG Types..... 5
  - 1.5 APG Weights ..... 5
  - 1.6 Base Rates..... 6
  - 1.7 Grouping..... 6
  - 1.8 Bundling/Packaging..... 6
  - 1.9 Capital Add-Ons..... 7
  - 1.10 No Capital Add-On..... 7
  - 1.11 Discounting..... 7
  - 1.12 Significant Procedure Consolidation..... 7
  - 1.13 Statewide Base Rates ..... 8
  - 1.14 Scope of Services..... 8
- 2 Reimbursement Components Affecting APGS ..... 10
  - 2.1 APG Fee Schedule..... 10
  - 2.2 Procedure Based Weight..... 10
  - 2.3 Units of Service ..... 10
  - 2.4 “Never Pay” APG Procedures ..... 11
  - 2.5 If Stand Alone, Do Not Pay (ISADNP)..... 11
  - 2.6 Modifiers..... 11
- 3 APG Billing Guidance ..... 12
  - 3.1 APG Rate Codes..... 12
  - 3.2 Visit and Episode Based APG Rate Codes..... 12
  - 3.3 Incompatible Visit Types ..... 13
  - 3.4 Rate Codes Carved Out of APGs..... 14
  - 3.5 Ambulatory Surgery Services..... 14
  - 3.6 Physician-Administered Drugs under APGs..... 14
  - 3.7 Patient Encounters with a Registered Nurse or a Licensed Practical Nurse ..... 17
  - 3.8 National Correct Coding Initiative (NCCI) Edits..... 18
- 4 Supportive Services within APGS ..... 19
  - 4.1 Dental Billing..... 19



- 4.2 Observation Services (APG 450)..... 21
- 4.3 Mental Health Services Rendered by an LCSW or LMSW ..... 23
- 4.4 Expanded After Hours Access..... 23
- 4.5 Medicaid Managed Care Plans ..... 24
- 4.6 Dually Eligible Medicare/Medicaid Beneficiaries ..... 24
- 5 Ancillary Services and Procedures..... 25
  - 5.1 Ancillary Policy for D&TC Facilities ..... 25
  - 5.2 Recurring Physical, Occupational & Speech Therapies (APG 270, 271 & 272)..... 26
  - 5.3 Radiology Services..... 26
  - 5.4 Immunizations/Vaccines Provided to Medicaid Members Age 19 and Under ..... 27
  - 5.5 Immunizations/Vaccines Provided to Medicaid Members Age 19 and Older..... 28
  - 5.6 Ordered Ambulatory Services ..... 29
  - 5.7 Family Planning Programs ..... 30
  - 5.8 Free Access to Family Planning Services for Managed Care Members..... 30
  - 5.9 Federally Qualified Health Centers – FQHCs..... 30
- 6 Specialty Clinics..... 32
  - 6.1 Dialysis Services ..... 32
  - 6.2 HIV Designated AIDS Centers (HIV DAC)..... 32
  - 6.3 Indian Health Centers ..... 33
- 7 APG Contact Information..... 34
- 8 APG Glossary..... 34



## **Policy and Billing Guidance** **Ambulatory Patient Groups (APGs)**

### **1 Background and Introduction to APGs**

#### **1.1 Purpose**

The purpose of this manual is to provide the Medicaid policy and billing guidelines relative to the Ambulatory Patient Group (APG) classification and reimbursement methodology.

#### **1.2 Overview of APG Reimbursement Methodology**

APGs are a reimbursement classification system utilized for the reimbursement of a facility's cost of outpatient care. The fundamental basis of APG reimbursement is the categorization of the contact between the patient and the health care professional. The contact could be categorized by either a procedure, a medical evaluation and management (E&M), or an ancillary service. For each type of interaction, a prospective "weight" and price is established that includes all routine services (e.g., blood tests, chest X-rays, etc.) associated with the visit and/or procedure. The cornerstone premise of the APG methodology is that if the costs for all routine services rendered during a visit or a procedure were included in the reimbursement made to the facility, a financial incentive exists to control the volume and frequency of the services rendered to the patient.

APGs are designed to include all types of resources used during an ambulatory or clinic visit, including but not limited to, professional services, pharmaceuticals, supplies, ancillary tests, equipment utilization, types of rooms, and treatment time. APGs are designed to group procedures and medical visits that share similar resource utilization, and costs. Similar resource utilization means that the resources used for a procedure or medical visit are relatively constant across all patients assigned to an APG. The APG reimbursement methodology is designed to

predict the average pattern of resource utilization of a group of patients assigned to an APG. The level of resource utilization is taken into consideration in the calculation of the APG reimbursement made to the provider.

In addition to resources utilization, patients classified within each APG also share similar clinical characteristics as well. Similar clinical characteristics are utilized within the APG classification system to categorize the reimbursement of services as they relate to a common organ system or etiology. The clinical characteristics determine the specific medical specialty that should typically provide care to the patients within the specific APG group, as well as the level of ambulatory resources needed to render care.

Furthermore, the APG reimbursement methodology takes into consideration the amounts and types of resources used during a visit and is adjusted based on the level of intensity of the services rendered. Reimbursement is made based on the patient's diagnosis, symptoms and acuity, and APGs then systematically package the costs of certain, associated ancillary labs and/or radiology services into the overall reimbursement of the associated significant procedure or medical visit to the facility.

Overall, APGs are designed to reimburse facilities based on the clinical characteristics of the patient, service level intensity, and resource utilization of the procedures conducted and/or medical visit.

### **1.3 APG Software**

APGs are classified and reimbursed using a software developed and published by 3M Health Information Systems (3M). The 3M "Grouper Pricer" software is used to apply any appropriate grouping, bundling, packaging, and discounting logic in order to calculate a final APG weight, and allowed reimbursement amount. Each procedure and diagnosis coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

Providers may wish to obtain a copy of the 3M APG Definition manual to understand how Current Procedural Terminology (CPT) codes map to APGs. The APG Definitions Manual and Grouper Pricer software is available through 3M's Website.

A review of the 3M "Grouper Pricer" terminology or "logic" concepts used in the adjudication of APG claims is referenced below.

## 1.4 APG Types

The Medicaid APG reimbursement methodology classifies and assigns any procedure code submitted for reimbursement into these main categories: significant procedure, medical visit, ancillary procedure classification, incidental, or unassigned. The reimbursement under APGs is driven by this classification methodology.

### MAIN APG TYPES

- Significant Procedures
- Medical Visits
- Ancillary Procedures
- Incidental Procedures
- Unassigned

#### Significant Procedures

A significant procedure is a procedure that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

#### Medical Visits

A medical visit is an encounter in which a patient receives medical treatment but does not have a significant procedure performed. Evaluation and management (E&M) codes are assigned to one of the medical visit APGs based on the primary diagnosis reported on the claim.

#### Ancillary Tests and Procedures

Ancillary tests and procedures are services ordered to assist in the patient’s diagnosis or treatment.

#### Incidental Procedures

An integral part of a medical visit usually associated with professional services being given to the patient. (Example: range of motion measurements).

#### Unassigned

Unassigned APG 999 is typically related to durable medical equipment or services not reimbursed through APG methodology.

A complete list of the APG types can be found via the APG crosswalk located on the New York State (NYS) Department of Health (DOH) website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/crosswalk/](https://www.health.ny.gov/health_care/medicaid/rates/crosswalk/).

## 1.5 APG Weights

APG “weight” is based on the resource intensity relative to all other APGs. The APG “weight” is a percentage used to reduce or increase the procedure’s reimbursement, depending on the APG grouper’s evaluation of the service line. The final “weight” for a given visit is multiplied by a provider-associated base rate. A single claim can be assigned multiple APGs, each of which carries its own “weight,” depending on procedure codes, modifiers, and in some cases, diagnosis codes.

The APG “Weights” list are available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm).

## 1.6 Base Rates

A base rate is the dollar value assigned to the rate code used to determine the total allowable Medicaid APG reimbursement. APG base rates take into consideration a variety of factors including, but not limited to the following:

- Type of provider and service;
- Region – downstate, upstate, statewide; and
- Case mix, visit volume, existing payment and target investment.

The “Article 28, OPWDD, OMH, and OASAS Base Rates” list is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm).

## 1.7 Grouping

APGs group procedures together that share similar clinical characteristics, service level intensity, and resource utilization for the purposes of reimbursement. Each procedure code submitted for reimbursement on a claim is grouped or assigned to a specific APG using the logic by the 3M Grouper Pricer software. When evaluation and management (E&M) codes are reported, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis in order to calculate reimbursement.

Once the APG grouping logic has been applied, the claim is then subjected to any applicable consolidation, bundling/packaging, and/or discounting of multiple significant, medical and/or ancillary procedures.

## 1.8 Bundling/Packaging

The 3M “Grouper Pricer” utilizes the APG reimbursement methodology logic to “Bundle” or “Package” certain ancillary and/or drug services into the reimbursement for the related significant procedure or medical visit. The related low level, inexpensive, and/or frequently provided ancillaries or drug services are included in the APG reimbursement for the significant procedures or medical visits they are associated with. However, some ancillary services, particularly those that are expensive or infrequently performed (such as MRI guidance for surgical procedures), are paid as separate ancillary APGs.

Medical visits are also designed to “Bundle” or “Package” with significant procedures as well, unless the type of visit is specifically excluded from bundling under the regulations. When certain significant procedures are performed on the same day as a medical visit, no packaging would occur, and the provider would receive reimbursement for both the medical visit, and the significant procedure. For example, medical visits will not be required to “Bundle” or “Package” with the following procedures:

- High intensity ancillary procedures (e.g., mammograms, MRIs, CAT scans, etc.);
- Dental procedures;
- Physical, speech and occupational therapy; and
- Counseling services.

The “Packaged Ancillaries in APGs” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/uniform\\_packaging.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/uniform_packaging.htm).

## 1.9 Capital Add-Ons

Capital Add-Ons are a per-visit additional reimbursement automatically added to the reimbursement of an APG claim based on a facility’s cost reports as reported to DOH. This add-on is only applied to claims for significant procedures and certain medical visits. In some cases, the APG reimbursement itself may cover the allowable capital cost. Capital add-ons are computed on a provider-specific basis, except for those capital add-ons applicable to hospital-based ambulatory surgery centers and free-standing ambulatory surgery centers, which are computed on a peer group basis.

The “Capital Add-ons” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm).

## 1.10 No Capital Add-On

These are procedures designated by DOH that are excluded from the “Capital Add-on”. This occurs when a claim is submitted for reimbursement that consists entirely of services on the “No Capital Add-on APGs” list or the “No Capital Add-on Procedure” list.

The “No Capital Add-On APG” list is available on the DOH website at  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on.htm).

The “No Capital Add-On Procedure” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on\\_procedures.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on_procedures.htm).

## 1.11 Discounting

When multiple significant and/or other procedures are performed or when the same ancillary service is performed multiple times, the standard APG reimbursement will be discounted automatically. Discounting recognizes the marginal cost of providing a second procedure to a patient during a single visit, which is less costly than providing the procedure by itself.

The standard rate of discounting within the APG reimbursement methodology is 50%. However, several additional APGs discount at a rate less than the 50% standard amount.

The “Non-50% Discounting APG” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/non-50\\_discounting.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/non-50_discounting.htm).

## 1.12 Significant Procedure Consolidation

Significant procedure consolidation is the consolidation of multiple related significant procedure APGs into a single APG for determining reimbursement. The significant procedure consolidation list is based on clinical judgment of the 3M product development. The significant procedure



consolidation list identifies, for each significant procedure APG, the other significant procedure APGs that are integral to the procedure and can be performed with relatively little additional effort.

Example: A Level I (primarily diagnostic) lower gastrointestinal endoscopy is consolidated into the Level II (primarily therapeutic) gastrointestinal endoscopy.

Unrelated significant procedures are not consolidated. Multiple unrelated significant procedures on the same date of service also are not consolidated in the APG classification system, but reimbursement for additional unrelated significant procedures will be discounted.

The “Significant Procedure Consolidation” list is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/rates/bundling/2016/index.htm](https://www.health.ny.gov/health_care/medicaid/rates/bundling/2016/index.htm).

### 1.13 Statewide Base Rates

Statewide Base Rate APGs do not reimburse differently based on the location where services were rendered. These services are paid uniformly across all regions in New York State.

The “Statewide Base Rate APGs” list is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/statewide\\_base\\_rate\\_apgs.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/statewide_base_rate_apgs.htm).

### 1.14 Scope of Services

APGs were developed to encompass the full range of ambulatory settings including same-day surgery units, hospital emergency rooms, and outpatient clinics. Below is a list of the applicable reimbursement settings:

- Hospital outpatient department (OPD)
- Hospital ambulatory surgery center
- Hospital emergency department (ED)
- Free-standing ambulatory surgery center
- Diagnostic and treatment center (D&TC)
- Office for People with Developmental Disabilities (OPWDD) clinic
- Office of Mental Health (OMH) clinic
- Office of Addition Services and Supports (OASAS) clinic
- Outpatient Dental clinic

The APG reimbursement methodology is NOT applicable to the following:

- Capitated reimbursements made on behalf of Medicaid
- Ordered Ambulatory services
- Professional physicians’ services in hospital settings billed using the Physician Fee Schedule
- Federally Qualified Health Centers (FQHCs), except when the FQHC has voluntarily agreed to participate in the APG reimbursement system
- Long term care, home care, and personal care services

- Practitioner office settings
- Independent labs
- Radiology providers

**Note:** Although the APG reimbursement methodology is not required for Medicaid managed care plans, plans may elect to use APGs for provider reimbursement based on their negotiated agreements with providers in their networks.

## **2 Reimbursement Components Affecting APGS**

This chapter provides information relative to the various reimbursement components utilized within APGs, and the reimbursement logic applied through the 3M Grouper Pricer when a claim is submitted for adjudication.

### **2.1 APG Fee Schedule**

There are certain procedures within APGs that are reimbursed through the APG Fee Schedule. Procedures assigned to the APG Fee Schedule are recognized by the submission of units and are exempt from APG logic, such as significant procedure consolidation, and discounting.

The APG “Fee Schedule” is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm).

### **2.2 Procedure Based Weight**

Procedure based weight is the “weight” assigned to a procedure, which determines the reimbursement instead of the “weight” assigned to the APG for that procedure. A procedure reimbursed in this manner will be reimbursed based on the “APG procedure-based weight” file. Procedure codes assigned to “procedure-based weight” file are designed to recognize the submission of units on the APG claim. The “procedure-based weight” and the number of units are used in the calculation of the APG reimbursement.

The APG “Procedure Based Weight” file is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm).

### **2.3 Units of Service**

Some procedures will be reimbursed based on procedure-specific weights rather than the APG weight. The procedure-based weight file identifies the weights for each procedure. The methodology utilizes the number of units submitted on the claim line in calculating the reimbursement for the procedures. Procedures that recognize the use of units of service when calculating reimbursements within APGs include, but are not limited to:

- Select Mental Hygiene Services
- Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)
- Patient education (e.g., diabetes and asthma self-management services, including services rendered by CDEs & CAEs)
- Nutrition counseling (e.g., CPT 97802 medical nutrition, individual 15 minutes)
- Crisis Management (e.g., CPT H2011 crisis intervention service, 15 minutes)
- Health/behavioral assessments (e.g., CPT 96150 assess health behavior, initial)

Providers should submit a single claim line for these procedures, indicating the total number of units that were administered.

The APG “Fee Schedule” is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm).

## 2.4 “Never Pay” APG Procedures

A “Never Pay” service is not reimbursable within the APG reimbursement methodology. Any service that is carved out or groups to a “Never Pay” APG will result in a \$0 reimbursement on the service line. Drugs that are carved out of APGs may be billed using the ordered ambulatory fee schedule.

Providers are still required to include any “Never Pay” services and/or procedures on claims submitted to Medicaid. Although no reimbursement will be made for any service and/or procedure that groups to a “Never Pay” APG, Medicaid will collect claims data, which may be utilized for future Medicaid rate development.

The “Never Pay Procedures” and “Never Pay APGs” lists (formerly known as “Carve Out” List) are available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/apg\\_carve\\_out.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/apg_carve_out.htm).

**Note:** Refer to section 5.6 of this manual for additional information on Ordered Ambulatory reimbursement.

## 2.5 If Stand Alone, Do Not Pay (ISADNP)

Procedures that map to either the “If Stand Alone, Do Not Pay APGs” and/or the “If Stand Alone, Do Not Pay Procedures” lists consist primarily of laboratory and radiology diagnostic tests, which are packaged/bundled globally into the APG reimbursement made to the facility for an associated significant procedure and/or medical visit. The procedures on either of the “ISADNP” lists do not qualify for a separate reimbursement on their own, or with other ISADNP procedures under the APG reimbursement methodology.

The “If Stand Alone, Do Not Pay APGs” list, and the “If Stand Alone, Do Not Pay Procedures” list, are available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/](https://www.health.ny.gov/health_care/medicaid/rates/methodology/).

## 2.6 Modifiers

Providers can indicate special circumstances that apply to the delivery of a services or procedure through the use of a modifier(s). The “NYS APG Modifiers” list contains a list of acceptable APG modifier codes and descriptions on when to use them. The list includes the modifier code, a short description of the code, the state agencies that require the modifier, effective date, applicable APGs, how the modifier may affect payment, and Medicaid Update article citation, if available.

The “NYS APG Modifiers” list is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/modifiers.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers.htm).

### 3 APG Billing Guidance

This chapter provides guidance on how to bill and submit claims using the APG reimbursement methodology.

#### 3.1 APG Rate Codes

The following are the primary Article 28 APG rate codes utilized when submitting a claim for reimbursement:

SETTING	SERVICE	VISIT RATE CODE	EPISODE RATE CODE
HOSPITAL	OPD CLINIC	1400	1432
HOSPITAL	AMBULATORY SURGERY	1401	
HOSPITAL	EMERGENCY DEPARTMENT		1402
HOSPITAL	SCHOOL BASED HEALTH PROJECT	1444	1450
HOSPITAL	OPD - MR/DD/TBI PATIENT	1501*	1489*
DTC	GENERAL CLINIC	1407	1422
DTC	AMBULATORY SURGERY	1408	
DTC	DENTAL SCHOOL	1428	1459
DTC	GENERAL CLINIC MR/DD/TBI	1435*	1425*
DTC	RENAL	1438	1456
DTC	SCHOOL BASED HEALTH PROJECT	1447	1453
DTC	GENERAL CLINIC APG MR/DD (EDIT EXEMPT)	1498	1495

\* Note: Rate codes 1501, 1489, 1435, and 1425 are to be utilized for Medicaid members identified with recipient exception codes RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”). An additional 20% enhancement has been added to the APG base rate for the services provided to these individuals.

There are additional rate codes utilized through APGs, including integrated service rate codes. Please see the following links below for additional information.

The “Hospital APG Rate Code Matrix” is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/rates/hospital/index.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/hospital/index.htm).

The “D&TC and ASC APG Rate Code Matrix” is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/rates/dtc/index.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/dtc/index.htm).

#### 3.2 Visit and Episode Based APG Rate Codes

APGs utilize rate codes to identify the type and duration of the encounter and use of either a “Visit” or “Episode” of care rate code.

The “Visit” rate code is utilized to capture all the APG services that are performed for a member on a single date of service. The “Visit” rate code recognizes each date of service submitted on a claim as a separate encounter.

The “Episode” rate code is utilized to capture all the medical visits and/or significant procedures that occur over the span of multiple dates of service. The “Episode” rate code is used to recognize the dates of service for the significant procedure and/or medical visit, including any associated ancillaries that are performed in preparation for or in follow-up to the significant procedure and/or medical visit. All dates submitted for reimbursement utilizing the “Episode” rate code will be considered a part of the same “Episode” regardless of the reported dates of service on the claim. Providers should report the actual dates of service for all of the procedures and/or services that are part of the “Episode.”

If procedures from two different “Episodes” of care are coded on the same claim, unwarranted discounting or consolidation may occur, resulting in underpayment to the APG biller.

Any “Visit” based claim submitted for a date of service that is included within an “Episode” claim will not be separately reimbursed. If two separate claims are submitted, the second claim will be denied, if the services were provided by the same provider, for the same patient, and have the same “from” date regardless of the rate code used. The provider should submit a single APG claim with all the procedures or services rendered within the member’s episode of care utilizing the “Episode” rate code.

### 3.3 Incompatible Visit Types

APGs do not allow for the reimbursement of certain combinations of APG rate codes submitted for the same patient for the same date of service (DOS), or within the same visit/episode of care. System edits are in place to deny multiple claims received for the submission of any APG and/or inpatient All Patient Refined-Diagnosis Related Groups (APR-DRG) claims.

Claims with an APG rate code that is “incompatible” or that conflicts with a claim already on file will be denied based on this logic. The APG claim will deny, and is not reimbursable, if there is an inpatient claim that has already been submitted for the same date(s) of service and has the same primary diagnosis.

A second claim for the same date of service, submitted by free-standing ambulatory surgery centers (Article 28) that either bill rate codes 1408 Surgery or 1425 General Clinic MR/DD/TBI (Episode), will be denied.

The APG billing restrictions will also apply to out-of-state facilities for rate codes: 1413 OPD, 1416 Surgery, 1419 ER, and 1441 OPD (Episode).

Claims submitted by OPDs using any combination of the following APG rate codes will be denied:

- 1400 OPD
- 1401 Surgery
- 1402 ED
- 1489 OPD - MR/DD/TBI Patient (Episode)
- 1501 OPD - MR/DD/TBI Patient

Claims submitted by D&TCs using any combination of the following APG rate codes will be denied:

- 1407 General Clinic
- 1408 Surgery
- 1422 General Clinic (Episode)

Additional information regarding “Ambulatory Patient Groups (APGs) Rate Code Combination Edits for Incompatible Visit Types” is available on the DOH website at:

[http://www.health.ny.gov/health\\_care/medicaid/program/update/2014/2014-03.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2014/2014-03.htm).

### 3.4 Rate Codes Carved Out of APGs

Certain rate codes are carved out of the APG reimbursement methodology. The rate codes that are carved out of APGs are instead reimbursed according to the methodology associated with that rate code.

The “Rate Codes Carved-Out of APGs” list is available on the DOH website at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/carve\\_out.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/carve_out.htm).

### 3.5 Ambulatory Surgery Services

A provider must be certified and have been issued an ambulatory surgery rate code in order to seek reimbursement from Medicaid for ambulatory surgery services. The appropriate ambulatory surgery rate code must be utilized for services rendered in an operating room, under general anesthesia or intravenous sedation. This policy also applies to any dental ambulatory surgery procedures.

#### Ambulatory Surgery Services Performed in an Emergency Department (ED)

Any procedure rendered in the ED must be billed using the ED rate code. However, if a member was initially seen in the ED and the visit resulted in the provision of a same day ambulatory surgery outside of the ED, the appropriate ambulatory surgery rate code should be used on the claim. Medicaid will only reimburse for ambulatory surgery services, when both ED and ambulatory surgery services are rendered on the same date of service.

#### Pre-Surgical Testing

Ancillary testing ordered in preparation for an ambulatory surgery procedure for a patient that is referred to the ambulatory surgery facility should be billed utilizing the ordered ambulatory fee schedule.

#### Post-Surgical Testing (e.g., pathology)

All post-surgical ancillary tests should be billed utilizing the ordered ambulatory fee schedule.

The Ordered Ambulatory Policy Guidelines and Fee Schedule is available on the eMedNY website at: <https://www.emedny.org/ProviderManuals/OrderedAmbulatory/>.

Please refer to section 5.6 of this manual for additional information regarding “Ordered Ambulatory” services.

### 3.6 Physician-Administered Drugs under APGs

Physician-administered drugs are processed in various ways under the APG reimbursement methodology:

- Certain physician-administered drugs are assigned to an APG and are weighted and reimbursed based upon the global average dosage administered.

- Certain physician-administered drugs are packaged and are included within the reimbursement for the associated medical visit (E&M) or significant procedure.
- Certain physician-administered drugs were removed from the weighted APG and were instead made reimbursable via the APG fee schedule.
- Physician-administered drugs that are carved out of APGs and listed on the ordered ambulatory fee schedule may be billed as an ordered ambulatory service based upon the drug's actual acquisition cost, by invoice to the provider.

#### Categories of Physician-Administered Drugs

- Reimbursed via Assigned APG
- Reimbursed via APG Fee Schedule
- Carved out, billed under ordered ambulatory

Providers should not bill multiple claim lines with the same J code on the same date of service, even if the drugs administered have different NDCs. If a provider bills in this manner and the drug is assigned to a single APG group, the provider will be overpaid; both claim lines will pay in full. To avoid this overpayment, providers should combine all units of the J code drug administered and bill it on one claim line with the NDC reported for the claim that has the highest number of units administered. If the same number of units were administered for each NDC/J code, choose one NDC.

Multiple lines may only be used when indicating drug waste. Medicaid will reimburse providers for the unused portion of a single-use vial of J-code drugs when the provider uses the "JW" modifier. Additional information pertaining to the use of the "JW" modifier is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/program/update/2015/2015-08.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-08.htm).

Physician-administered drugs reimbursed via the APG fee schedule should be submitted utilizing the number of units of the drug that was administered, along with the provider's actual acquisition cost for the drug. Drugs listed on the fee schedule will be reimbursed up to the maximum number of units allowed at the price per unit listed. Reimbursement for each covered physician-administered drug shall not exceed the lower of either the provider's actual acquisition cost (net any rebate or discount) or the price indicated on the APG fee schedule. Providers must retain documentation (invoices) proving the acquisition cost of drugs submitted for reimbursement, to be made available upon request by DOH.

Drugs assigned to a payable APG (i.e., not paid through the fee schedule) will be reimbursed based on the statewide base rate, regardless of geographic location (i.e., upstate, downstate), or rate code. Drugs assigned to a payable APG should be billed utilizing the applicable J-code, the number of units that were administered, and the provider's charges.



- Class I Pharmacotherapy (APG 435)
- Minor Pharmacotherapy (APG 496)
- Class I Therapeutic Radiopharmaceuticals (APG 243)

These drugs are included/packaged into the APG reimbursement for the associated medical visit or significant procedure made to the facility. Therefore, no additional reimbursement will be made.

- Class II – VII Pharmacotherapy Drugs (APGs 436-440 & 444)
- Class VIII – XII Combined Chemotherapy & Pharmacotherapy Drugs (APG 460-464)
- Class II & III Therapeutic Radiopharmaceuticals (APG 244 & 245):

These drugs do not package within APGs and will be separately reimbursable at the line level. Providers should submit a claim for reimbursement using their charges; however, the APG will be reimbursed based upon the weighted average for the drugs that map to the specific APG, regardless of cost.

- Chemotherapy (APG 430-434, 441 & 443)
- Class XIII & XIV Combined Chemotherapy & Pharmacotherapy Drugs (APG 465 & 466)
- Minor Chemotherapy Drugs (APG 495)
- Class IV Therapeutic Radiopharmaceuticals (APG 246)

These drugs are carved out of the APG reimbursement methodology. Providers should seek reimbursement for these services via the ordered ambulatory fee schedule.

The Ordered Ambulatory Fee Schedule is available on the eMedNY website at: <https://www.emedny.org/ProviderManuals/OrderedAmbulatory/>.

The “Never Pay” APGs and procedures lists are available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/apg\\_carve\\_out.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/apg_carve_out.htm).

### National Drug Code (NDC) Reporting Requirement on Physician-Administered Drugs

Providers are required to report the NDC for all physician-administered drugs. If the NDC is not referenced on the claim, Medicaid will not provide reimbursement for the drug.

### UD Modifier (340B Drugs)

Drugs obtained at the 340B price are identified by appending the UD modifier. The provider is required to report the NDC on a claim for the reimbursement of 340B drugs. The provider must include the number of units administered and their actual acquisition cost, by invoice, in the charges field of the claim. Note: JG and TB modifiers are used for Medicare 340B drug claims and should be reported to Medicaid on your crossover claim.

Additional information regarding billing instructions for 340B drug claims is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/program/update/2017/2017-06.htm#340b](https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-06.htm#340b).

Additional information regarding billing instructions for NDC on physician administered drugs is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/update/2019/2019-04.htm#ndc](https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-04.htm#ndc).

## **3.7 Patient Encounters with a Registered Nurse or a Licensed Practical Nurse**

Patient encounters with only a registered nurse (RN) or a licensed practical nurse (LPN) generally are not reimbursable under Medicaid except in the following limited circumstances:

- An RN administers chemotherapy or other infusion drugs under a physician's order in a clinic setting. An APG claim should be billed to Medicaid for the administration. An E&M code should not be reported on the APG claim.
- An RN or LPN administers an immunization within their scope of practice under a patient specific or non-patient specific standing order and the patient does not see a physician, physician assistant, nurse practitioner or licensed midwife during the same visit.
- An RN or LPN performs a urine pregnancy test upon a patient specific order of a licensed physician, physician assistant, nurse practitioner, or nurse midwife and the patient does not see a physician, physician assistant, nurse practitioner or nurse midwife during the same visit. An APG claim should not be billed to Medicaid in this instance. Urine pregnancy test, 81025, should be billed to Medicaid using the laboratory ordered ambulatory fee schedule.
- An RN or LPN administers Depo-Provera within their scope of practice under a patient specific order and the patient does not see a physician, physician assistant, a nurse practitioner, or a licensed midwife during the same visit. An APG claim should not be billed to Medicaid. Depo-Provera, J1050, should be billed to Medicaid using the ordered ambulatory fee schedule.

- An RN or LPN performs allergy injections upon a patient specific order of a licensed physician, physician assistant, nurse practitioner, or nurse midwife and the patient does not see a physician during the same visit. An APG claim should be billed to Medicaid for the injection. An E&M code should not be reported on the claim.

RNs and LPNs may provide service only within their respective scopes of practice as defined by the State Education Department laws, rules, and regulations. Providers may obtain specific information about practitioner scope of practice at: <http://www.op.nysed.gov/prof/nurse/>.

### **3.8 National Correct Coding Initiative (NCCI) Edits**

NCCI edits were developed by CMS to support national practice, coding and billing standards. NCCI edits are utilized by Medicare and most private insurers and reflect nationally accepted correct coding standards. NCCI edits are used to prevent inappropriate reimbursement of services that should not be reported together for the same date of service by the same provider; services that are integral to another comprehensive service separately coded; and services that should never be performed with another service or procedure. The provider may need to append an applicable modifier on a claim line to indicate multiple, distinct patient encounters, provided by the same provider, on the same date of service to reflect the nature of services provided.

Additional information regarding NCCI edits, and the use of modifiers, is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/apg/docs/ncci\\_edits\\_applied\\_apgclaims.pdf](http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/ncci_edits_applied_apgclaims.pdf).

## 4 Supportive Services within APGS

This chapter provides guidance relative to the reimbursement of additional services rendered in an Article 28 facility.

### 4.1 Dental Billing

Dental services rendered in an Article 28 OPD, ED or D&TC facility are reimbursable through the APG reimbursement methodology. The only exceptions to this policy are orthodontia and implants, which are carved-out of APGs, and should be billed utilizing the dental practitioner fee schedule.

Clinics are expected to abide by the frequency limits applicable to dental procedures listed in the Dental Provider Manual. Refer to the Dental Provider Manual for policy guidance on dental services, which is available on the eMedNY website at:

[https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental\\_Policy\\_and\\_Procedure\\_Manual.pdf](https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf).

**Note:** Prior approval is not required for any dental services provided in a clinic setting and billed by the clinic.

#### Dental Procedures and E&M Visits

Evaluation and Management (E&M) visits do not package with dental procedures or exams within APGs. If a patient has a medical visit (E&M) with a practitioner (other than the dentist), and a dental visit on the same day, both procedures will be reimbursed at the line level.

#### Dental Anesthesia (APG 375)

A provider must indicate on their claim if dental anesthesia was provided in conjunction with any dental procedure. Dental anesthesia procedure codes D9222, D9223, D9239, and D9243 will be reimbursed via the APG “Procedure Based Weights” file. There is a 4 Unit maximum for dental anesthesia (e.g., 1 unit for D9239 and a maximum of 3 units for D9243).

- D9222 – Deep anesthesia, 1<sup>st</sup> 15 min;
- D9223 - General anesthesia each 15 min; and
- D9239 – IV moderate sedation, 1<sup>st</sup> 15 min;
- D9243 - IV sedation each 15 min.

Dental anesthesia code D9248, non-intravenous conscious sedation, (APG 490) is only reimbursable for eligible MR/DD/TBI recipients (as defined by recipient exception codes 81 or 95). Procedure code D9248 will also be reimbursed via the APG “Procedure Based Weights” file.

#### Dental Hygienists

For routine dental care, when a patient is seen by a dentist and dental hygienist on the same date of service, one claim should be submitted. All services provided should be reported on the claim. D0190 should not be billed since the patient will be seen by a dentist providing an oral exam.

When oral assessments are provided by a registered dental hygienist, in accordance with a collaborative practice agreement, Medicaid will reimburse Article 28 clinics for these

assessments. A dental hygienist screening of a patient should be billed using D0190. The clinic should bill for any other procedures provided by the hygienist within their scope of practice (e.g., prophylaxis). These claims will be identified by the D0190 code to indicate that a dental hygienist performed the services provided. Please note that D0190 should only be billed for screening performed by a dental hygienist. Claims billed with a screening for a patient using D0190 will not include a capital add-on.

Additional information regarding dental hygienist billing is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-08.htm](https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-08.htm).

### Orthodontia

Orthodontia is a carved-out service not reimbursed under APGs. Reimbursement for orthodontia services will be made using the dental practitioner fee schedule. Orthodontia procedures group to the “Never Pay APGs” list, as they are not reimbursable via APGs. The dentist must obtain any necessary prior approvals before rendering orthodontia services.

### Dental Ancillaries

Dental ancillaries are reimbursable within APGs. Dental ancillaries are subject to the APG reimbursement consolidation, discounting, packaging, and “If Stand Alone, Do Not Pay” logic. Dental ancillary procedures that group to the “ISADNP” APG list do not qualify for reimbursement on their own when they are the only service/procedure submitted on a claim for reimbursement. Multiple ancillaries that group to the same APG will discount at between 10% and 50% based on the procedure codes reported on the claim. Multiple ancillaries that group to different APGs will make a full reimbursement at the line level.

The “If Stand Alone, Do Not Pay” list is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm)

### Dental Ambulatory Surgery Services

Dental ambulatory surgery performed in an operating room, under general anesthesia and/or requiring intravenous sedation is billed using an ambulatory surgery rate code.

Additional information regarding dental services rendered in an operating room/ambulatory surgery setting may be found in section [3.5](#) of this manual.

### Multiple Day Dental Procedures

If a dental procedure requires multiple visits to complete, a separate APG claim should be submitted for each distinct date of service.

### Dental Sealants (APG 372)

Dental sealants (D1351) should be coded once for each tooth that is sealed on a single date of service. If four teeth are sealed during a visit, the provider should code D1351 on four (4) separate claim lines, each with the same date of service.

Dental Behavioral Management

Dental Behavioral Management is a per visit incentive used to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat members with a developmental disability. Procedure code D9997 may only be utilized to seek reimbursement for individuals identified with a recipient exception code of RE 81 (TBI Eligible) or RE 95 (OPWDD/Managed Care Exemption). This code is effective July 1, 2020.

Dental Implants (APG 381 and 382)

Dental implants are a carved-out service not reimbursed under APGs. Reimbursement for dental implant services will be made using the dental practitioner fee schedule. The dentist must obtain any necessary prior approvals before rendering dental implant services.

**4.2 Observation Services (APG 450)**

Observation services may be separately reimbursable within APGs in addition to an emergency department (ED) and/or medical visit (E&M) depending on the amount of time the member was under observation. A hospital may seek reimbursement for observation services for members who are seen, evaluated, and admitted via the hospital's ED, and for whom a diagnosis and determination concerning admission, discharge or transfer cannot be accomplished within eight (8) hours of admission to observation, but can reasonably be expected within 48 hours. A patient must be in observation status for a minimum of eight (8) hours with clinical justification for this service to be reimbursable. This is in addition to any time the patient spent in the ED prior to receiving observation services. Hospitals may seek reimbursement for up to 48 hours of observation services (excluding time in the ED), at which time the patient must be admitted as an inpatient or discharged. If the patient must be transferred to another facility, the ED and observation services may be submitted for reimbursement. If the patient is admitted to inpatient status, only the inpatient admission may be submitted for reimbursement, and the associated ED and observation services will not be separately reimbursed.

Observation services may be provided in the following settings:

- Approved units that have existing waivers
- Existing observation units (incompliance with current regulations as 10 NYCRR 405.32
- New distinct observation units (in compliance with 10 NYCRR 405.32
- Inpatient beds
- Emergency Departments

Hours in ED	Hours in Observation Unit:	Provider Billing:
3 hours	6 hours	Payment for ED visit only - do not report observation services on the APG claim.
3 hours	9 hours	Payment for ED visit and observation (9 units)
8 hours	48 hours	Payment for ED visit and observation (48 units)
8 hours	4 hours	Payment for ED visit only - do not report observation services on the APG claim.

Observation Services Billing Requirements

Observation services should be billed under APG rate code 1402, and CPT/HCPCS code G0378 (hospital observation service, per hour), and are subject to consolidation and bundling logic. The G0378 should be submitted for reimbursement on a single claim line, indicating the date in which

the observation began, and include the total number of hours of observation in the unit field. The appropriate CPT/HCPCS codes for all ancillary services provided to the patient while in observation status should also be reported on the claim. Facilities should code G0378 only when the length of stay for observation services is eight (8) or more hours. If the observation service is less than eight (8) hours, the observation portion of the stay is not reimbursable by Medicaid, and the observation code should not be reported on the APG claim.

Only those hours the patient is in observation status may be reimbursed utilizing the G0378. Significant procedures or high intensity ancillaries (e.g., MRI, PET scans, CT scans) will cause G0378 to package, meaning it will not be paid separately. Low-level ancillaries (e.g., X-rays, laboratory tests) and drugs will not cause G0378 to package and observation will be reimbursed separately.

The UC modifier should be appended to G0378 to reflect observation services rendered in a distinct observation unit. Facilities will be reimbursed an enhanced hourly rate (20 percent higher) for providing observation in designated units when the UC modifier is reported on the claim. However, observation services provided in non-designated units (scattered site beds) should be coded using G0378 without the UC modifier.

**Note:** Observation services are available to in-state hospital facilities licensed pursuant to Article 28 of the Public Health Law.

#### Direct Admission for Hospital Observation

A hospital may also seek reimbursement for services provided to members that are directly admitted for the purpose of observation. Hospitals should utilize the procedure code G0379 when observation services are the result of a direct admission to “observation status” without an associated ED visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. The provider must include the following procedure codes when seeking reimbursement for Direct Admission Hospital Observation Care:

- G0378 - Hospital observation (per hour) and indicate the number of hours of observation in the unit field (minimum of 8, and a maximum of 48 hours). The provider must append the “UC” modifier to indicate if the observation services were rendered in a designated observation unit; and
- G0379 - Direct Admission for Hospital Observation Care.

Both procedure codes (G0378 & G0379) must be present on the APG claim in addition to an appropriate primary diagnosis code. The Direct Admission for Hospital Observation Care (G0379), which initially groups to APG 491, will be assigned to one of the medical visit APGs based on the primary diagnosis reported on the claim.

Facilities that do not have an ED rate code may instead utilize their clinic rate code when seeking reimbursement for direct admission observation. Facilities that have been assigned both an ED and clinic rate code must utilize their ED rate code when seeking reimbursement for this service.

Additional information regarding coverage of observation services is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/program/update/2013/2013-05.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-05.htm).

### 4.3 Mental Health Services Rendered by an LCSW or LMSW

Medicaid allows for the reimbursement of mental health counseling provided to certain populations by a licensed clinical social worker (LCSW) or a licensed master social worker (LMSW) in an Article 28 hospital OPD or D&TC. Medicaid will reimburse for mental health counseling provided by LCSWs/LMSWs to children and adolescents under 21 years-of-age, and pregnant women up to 12 months postpartum post-partum (based on the date of delivery or end of pregnancy). The need for a patient to receive post-partum counseling, regardless of diagnosis, is based on medical necessity.

The following rate codes may be used for Hospital Outpatient Department and D&TC reimbursement for mental health counseling when provided by a LCSW/LMSW.

The following are rate codes for mental health counseling provided by an LCSW/LMSW:

- 4257 - Individual counseling (psychotherapy) approximately 20-30 minutes.
- 4258 - Individual counseling (psychotherapy) approximately 45-50 minutes.
- 4259 - Family counseling (psychotherapy with or without patient)

The following rate codes may be utilized by School Based Health Centers for the reimbursement of mental health counseling provided by an LCSW/LMSW.

The following are rate codes for mental health counseling provided by an LCSW/LMSW:

- 3257 - Individual counseling (psychotherapy) approximately 20-30 minutes.
- 3258 - Individual counseling (psychotherapy) approximately 45-50 minutes.
- 3259 - Family counseling (psychotherapy with or without patient)

Additional information regarding Medicaid coverage of mental health counseling by LCSWs and LMSWs rendered in an Article 28 hospital OPD or D&TC is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/program/update/2011/2011-06.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-06.htm).

### 4.4 Expanded After Hours Access

A hospital OPD and a D&TC may seek additional reimbursement for scheduled visits occurring in the evening, on a weekend or a designated national holiday.

- An evening visit is one which is scheduled for and occurs after 6:00 p.m.
- A weekend visit is one which is scheduled for and occurs on Saturday or Sunday.
- A holiday visit is one which is scheduled for and occurs on a designated national holiday.

Providers should use the following CPT codes as appropriate when billing for the expanded “after hours” additional reimbursement:

- 99050 - Services provided at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., designated national holidays, Saturday or Sunday), in addition to basic service.



- 99051 - Services provided during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

The above CPT codes are not reimbursable if they are the only procedure(s) listed on the claim. They are reimbursed only when accompanied by a separate medical service or procedure.

Additional information regarding enhanced reimbursement for expanded “after hours” access is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/program/update/2008/2008-10.htm](https://www.health.ny.gov/health_care/medicaid/program/update/2008/2008-10.htm).

#### 4.5 Medicaid Managed Care Plans

Medicaid Managed Care plans may or may not choose to use the APG reimbursement methodology.

To the extent Medicaid managed care plans are statutorily or contractually required to reimburse providers the Medicaid rate of payment for covered services provided to plan members (e.g., payment to non-participating providers for emergency services or reimbursement made to academic dental centers for dental services), plans must determine the appropriate reimbursement that would have paid under Medicaid APGs.

#### 4.6 Dually Eligible Medicare/Medicaid Beneficiaries

Medicaid reimburses the full annual deductible for dually eligible Medicare/Medicaid members. Additionally, Medicaid pays the lower of the Medicare Part B coinsurance amount or the difference between the Medicare payment and the APG payment.

Additional information regarding limitations on Medicare Part B coinsurance is available on the DOH website at: [https://www.health.ny.gov/health\\_care/medicaid/program/update/2011/2011-08.htm](https://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-08.htm).

##### Medicaid covered services not covered by Medicare

An Article 28 clinic may utilize the following rate codes to seek reimbursement from Medicaid for dually eligible beneficiaries for Medicaid covered services not covered by Medicare (e.g., dental procedures, after hours, or vision care).

- 1126 - MA Covered Non-Medicare Covered Services For Duals – OPD
- 1128 - MA Covered Non-Medicare Covered Services For Duals – D&TC
- 1054 - MA Covered Non-Medicare Covered Services For Duals – MR/DD/TBI OPD
- 1057 - MA Covered Non-Medicare Covered Services For Duals – MR/DD/TBI D&TC

**Note:** None of the above referenced rate codes reimburse a capital add-on.

Providers must submit two (2) separate claims for members that receive both Medicare and non-Medicare covered services on the same date of service.

- A Medicaid crossover APG claim (e.g., rate code 1400, 1407, 1432, 1435, or 1501) for services that are covered by both Medicare and Medicaid, and

- A Medicaid-only APG claim (i.e., rate code 1054, 1057, 1126, or 1128) for non-Medicare covered services (e.g., dental procedures, after hours, or vision care).

Medicaid will reimburse the first claim for the Medicare deductible and/or coinsurance amount (subject to the Medicaid cost-sharing limit), and the second claim will reimburse based upon the APG reimbursement methodology for the submitted procedure(s).

Dually Eligible Members with Developmental Disabilities (DD) or Traumatic Brain Injury (TBI) Providers may utilize either rate code 1054 (OPD) or 1057 (D&TC) when submitting a claim for enhanced reimbursement for a dually eligible Medicare/Medicaid member with MR/DD/TBI. These members are identified with an eligibility exception code of RE 95 (DD) and RE 81 (TBI).

## **5 Ancillary Services and Procedures**

This chapter provides billing guidance relative to the APG reimbursement of ancillary tests and procedures, and various other minor procedures performed in an Article 28 setting.

### **5.1 Ancillary Policy for D&TC Facilities**

D&TCs are subject to the U6 modifier ancillary policy. In order to receive payment based on APG logic for the ancillary procedure codes that group to select APGs, the U6 modifier must be coded at the line level.

The D&TC should append the U6 modifier if;

- The provider performed the service in house, or
- The provider will pay the lab or radiology provider for the service rendered.

When the U6 modifier is appended onto the service line, the ancillary service or procedure will reimburse according to the APG logic and will either “pay” or “package” as normal.

The D&TC should not append the U6 modifier if;

- The provider did not perform the service, and
- The lab or radiology provider that performed the service will bill Medicaid directly.

When the U6 modifier is not appended onto the service line, the ancillary service or procedure will make a zero (\$0.00) or negative (e.g., -\$6.90) reimbursement based upon its assigned APG. Medicaid reduces APG reimbursement for the clinic ordering the ancillary service in anticipation of receiving a separate service provider’s claim for rendering the ancillary service.

The “APG Ancillary Policy” is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/policy/](https://www.health.ny.gov/health_care/medicaid/rates/policy/).

Additional information regarding “Diagnostic and Treatment Centers Electing to Contract for Procedures Subject to the Ancillary Policy” is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/policy/freestanding\\_dtc\\_ancillary\\_policy.htm](https://www.health.ny.gov/health_care/medicaid/rates/policy/freestanding_dtc_ancillary_policy.htm).

## 5.2 Recurring Physical, Occupational & Speech Therapies (APG 270, 271 & 272)

Recurring therapies such as Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) that span multiple dates of service should be submitted for reimbursement utilizing the “Visit” rate code. The provider may seek reimbursement for multiple dates of service (DOS) on a single APG claim by using the “Visit” based rate code. The use of an “Episode” based rate code will cause the claim to discount incorrectly for these instances.

Medicaid fee-for-service (FFS) will require prior authorization (PA) for most medically necessary occupational, physical, and speech therapy visits. Certain Medicaid members, settings, and circumstances are exempt from prior authorization.

Additional information regarding exemptions from prior authorization is available on the eMedNY website at:

[https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation\\_Manual\\_Policy\\_Guidelines.pdf](https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation_Manual_Policy_Guidelines.pdf).

Further instructions on obtaining a prior authorization through the Dispensing Validation System (DVS) is available on the eMedNY website at:

[https://www.emedny.org/HIPAA/QuickRefDocs/ePACES\\_Obtaining\\_DVS\\_for\\_OT\\_PT\\_and\\_ST.pdf](https://www.emedny.org/HIPAA/QuickRefDocs/ePACES_Obtaining_DVS_for_OT_PT_and_ST.pdf).

Most recurring therapies are reimbursed via the APG “Procedure Based Weight” file instead of being reimbursed via standard APG logic. Providers must include the number of units on the claim that corresponds to the amount of therapy time rendered to the member. However, procedures that are reimbursed via APGs will be subject to any applicable consolidation, bundling/packaging, and/or discounting logic. Recurring therapy procedures that group to the same APG will be discounted at a rate of 25% rather than the usual 50%.

The “Non-50% Discounting APG” list is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/non-50\\_discounting.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/non-50_discounting.htm).

### Modifier Usage

Providers must append the applicable modifier for services delivered under an outpatient occupational therapy (GO), physical therapy (GP), or speech-language pathology (GN) plan of care when submitting a claim for the reimbursement of recurring therapies.

The “NYS APG Modifiers” list is available on the DOH website at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/modifiers.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers.htm).

## 5.3 Radiology Services

Providers must obtain any necessary prior approval prior to performing certain diagnostic imaging services for New York Medicaid FFS members. Prior approval will be required for the reimbursement of certain radiology procedures within APGs. Failure to obtain a prior approval may delay or prevent the reimbursement of a claim.

Please refer to section 3.6 of this manual for additional information regarding the reimbursement for professional billing.

Additional information regarding radiology prior approval is available on the eMedNY website at: <https://www.emedny.org/ProviderManuals/Radiology/index.aspx>.

## **5.4 Immunizations/Vaccines Provided to Medicaid Members Age 19 and Under**

Immunizations and vaccines administered in an Article 28 setting to members age 19 and under are reimbursed through APGs as outlined below.

### Vaccines for Children (VFC) Program

The federal government funds certain routine childhood vaccines at no cost to those providers who are registered with the Vaccines for Children (VFC) Program. The VFC program provides free vaccines to children up to 19 years of age. Medicaid providers administering these state-supplied vaccines through the VFC Program to Medicaid members must append the “SL” modifier to the vaccine CPT code line to indicate the administration of a free, state-supplied vaccine. Providers will be reimbursed a flat \$17.85 for the administration of the vaccine. No separate or additional vaccine administration code is needed. This includes reimbursement for Pneumococcal, Influenza and all other VFC vaccinations in Article 28 clinics (including FQHCs that opt into APGs), and Local County Health Departments.

Additional information regarding the “Vaccines for Children” (VFC) program is available on the DOH website at: [https://www.health.ny.gov/prevention/immunization/vaccines\\_for\\_children.htm](https://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm).

### School Based Health Centers (SBHC) Billing for Vaccines

Influenza and pneumococcal vaccinations provided at SBHCs for either Medicaid managed care or FFS members are billable using the following, non-APG rate codes.

- Influenza – Rate code 1381
- Pneumococcal – Rate code 1383

Providers will be reimbursed a flat \$17.85 for the administration of the vaccine since the vaccine is provided free of charge through the VFC program.

SBHCs should bill for all other vaccinations utilizing one of the following APG rate codes. The provider must append the “SL” modifier to indicate the administration of a free, state-supplied vaccine.

- Hospital Outpatient Department SBHC Rate codes – Visit 1444; Episode 1450
- Diagnostic & Treatment Center SBHC Rate codes – Visit 1447; Episode 1453

Billing Summary for Vaccines provided through the VFC program for children <19 years old in various settings

SETTING / FACILITY	AGE	VFC / FREE/ PP (Provider Paid)	MODIFIER	ADMIN CODE NEEDED	VACCINE CPT NEEDED	SPECIAL RATE CODE NEEDED	ORDERED AM BILLING	APG BILLING	ADMIN FEE
Article 28 - All other vaccinations including FLU & Pneumococcal	<19	VFC	SL	No	Yes	No	No	Yes	\$17.85
SBHC -FLU / Pneumococcal	<19	VFC	-	NO - you need to use special Rate Code	Yes	FLU = 1381 Pneum = 1383	No	No	\$17.85
SBHC-All other vaccinations	<19	VFC	SL	No	Yes	No	No	Yes	\$17.85
Local County Health Departments	<19	VFC	SL	No	Yes	No	No	Yes	\$17.85

### 5.5 Immunizations/Vaccines Provided to Medicaid Members Age 19 and Older

Immunizations and vaccines administered in an Article 28 setting to members age 19 and older are reimbursed through APGs as outlined below.

#### Vaccines Provided to Medicaid Members Age 19 and Older

Provider paid vaccinations for influenza and pneumococcal administered to Medicaid members age 19 and older are reimbursed via APGs. In addition to the APG line item reimbursement, a separate reimbursement of \$13.23 will be made for the administration of influenza and/or pneumococcal vaccine when the following vaccine administration codes are added to the claim.

- Influenza – G0008
- Pneumococcal – G0009

All other provider-paid vaccinations administered to Medicaid members age 19 and older, are also reimbursed via APGs. No separate vaccine administration code is required. Reimbursement for vaccine administration is included within the APG reimbursement made to the facility.

Providers that administer any free, or state-supplied vaccines, including influenza and pneumococcal, to Medicaid members age 19 and older must append the “FB” modifier to the vaccine code administered on the service line. Providers will be reimbursed a flat \$13.23 for the administration of the vaccine. No separate vaccine administration code is required.

Billing Summary for Vaccines provided through the Article 28 facilities for individuals greater than 19 years old

SETTING / FACILITY	AGE	VFC / FREE/ PP (Provider Paid)	MODIFIER	ADMIN CODE NEEDED	VACCINE CPT NEEDED	SPECIAL RATE CODE NEEDED	ORDERED AM BILLING	APG BILLING	ADMIN FEE
Article 28 - All other vaccinations including FLU & Pneumococcal	≥19	FREE	FB	No	Yes	No	No	Yes	\$13.23
Article 28 - FLU / Pneumococcal	≥19	PP	-	G0008 FLU or G0009 Pneum	Yes	No	No	Yes	\$13.23
Article 28 - All other vaccinations	≥19	PP	-	No	Yes	No	No	Yes	Administration included in APG payment
Local County Health Departments	≥19	FREE	FB	No	Yes	No	No	Yes	\$13.23
Local County Health Departments	≥19	PP	-	No	Yes	No	No	Yes	Administration included in APG payment

Federally Qualified Health Centers (FQHC) Billing for Vaccines

FQHCs that opt out of APGs receive the prospective payment system (PPS) rate for all services provided to a Medicaid member for the entire visit. An FQHC that has not opted into APGs may bill the PPS rate if an immunization (including flu/pneumococcal) is administered as part of an encounter in which a significant procedure and/or medical visit also occurs. If an immunization is the only service provided, the PPS rate should not be billed; the immunization administration should be billed using the ordered ambulatory fee schedule.

**5.6 Ordered Ambulatory Services**

An ordered ambulatory service is a specific service that has been carved out of APGs (e.g., chemotherapy drugs, genetic testing) or is being performed by a hospital or D&TC on an ambulatory basis upon the order and referral of a qualified physician, nurse practitioner, physician assistant, licensed midwife, dentist, or podiatrist not affiliated with the hospital or D&TC that is providing the ordered ambulatory service. Ordered ambulatory services are billed using the Medicaid fee schedule. Ordered ambulatory services should not be billed using APG rate codes as they are not reimbursable within the APG reimbursement methodology.

The Ordered Ambulatory “Fee Schedule” is available on the eMedNY website at: <https://www.emedny.org/ProviderManuals/OrderedAmbulatory/>.

## **5.7 Family Planning Programs**

Some Medicaid members will access family planning services through their comprehensive Medicaid coverage. Other members have partial coverage for only family planning and related services through the Family Planning Benefit Program (FPBP). FPBP provides Medicaid coverage for a range of family planning services to males and females of childbearing age with incomes below 223% of the poverty level.

The Family Planning Extension Program (FPEP) provides 24 months of family planning services to women who were pregnant while in receipt of Medicaid (regardless of how that pregnancy ended), but who are no longer eligible for MA after their 60-day post-partum period.

Special processing is needed for FPBP/FPEP claims. DOH requires that these claims contain an applicable diagnosis code (Z30 series) to receive reimbursement for a family planning procedure. All claims for family planning services must also contain a "Y" in the "Family Planning" indicator box in the header of the claim.

Additional information regarding the Family Planning Programs is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-01.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-01.htm).

## **5.8 Free Access to Family Planning Services for Managed Care Members**

Medicaid free access rules allow for Medicaid managed care members in all Medicaid plans to obtain family planning from their plan providers or from any Medicaid fee-for-service provider without a referral or approval. Providers that participate with a member's Medicaid managed care plan must seek reimbursement from that health plan. If the provider does not participate in the member's plan, they may bill Medicaid fee-for-service. Providers that are billing fee-for-service (FFS) Medicaid should use the appropriate APG rate codes. Providers must report a family planning diagnosis code (Z30 series) and a "Y" in the family planning indicator box to receive payment for their claim.

## **5.9 Federally Qualified Health Centers – FQHCs**

FQHCs may choose to participate in the APG reimbursement methodology and receive reimbursement via APGs, or they may opt to continue to receive reimbursement under their existing prospective payment system (PPS) rate methodology. FQHCs that opt to participate in the APG reimbursement methodology as an "alternative rate setting methodology" must complete and return the "FQHC Medicaid Reimbursement Option Declaration" form declaring their intent to "opt in" to APGs. Hospitals and D&TCs must return the form within the periods specified by DOH. Failure to submit this form in a timely manner will be considered a decision by the FQHC to continue to receive reimbursement via the PPS rate methodology.

An FQHC that chooses to receive reimbursement via the APG reimbursement methodology will continue to receive reimbursement in this manner until the FQHC submits a request in writing to DOH stating that they no longer wish to participate in APG reimbursement and want to be placed back on the PPS reimbursement method. Such notification may be filed prior to November 1 of each year and will be effective for dates of service on and after January 1 of the following year.

Similarly, an FQHC that decides to not “opt in” to receive reimbursement via APGs may still be able to do so at a later time by filing the above referenced “Option Declaration” form prior to November 1 of each year, and the change will be effective for dates of service on and after January 1 of the following year.

Potential benefits of selecting the APG reimbursement methodology include the opportunity to seek reimbursement for certain, primary care enhancements that are built into APG rates (e.g., diabetes, asthma education and expanded hours access). An FQHC provider with multiple service locations may opt into APGs for reimbursement at some of their locations. Only those service locations that opt into the APG reimbursement methodology will be reimbursed in that manner and be able to receive the reimbursement enhancements that are built into the APG rates.

Certain FQHC services, such as group and off-site services, will be carved-out of the APG reimbursement methodology. FQHCs “opting in” to APGs will be able to continue to bill the following carved-out rate codes for these services:

- 4011 – FQHC Group Psychotherapy
- 4012 – FQHC Off-Site Visit

Each FQHC that chooses to participate in the APG reimbursement methodology will be eligible to receive a supplemental fee-for-service (FFS) reimbursement reflecting the difference between actual APG reimbursement, and the amount the FQHC facility would have otherwise been reimbursed under the PPS rate, if the latter is higher. The PPS rate is defined in Public Health Law 2807(8) as an all-inclusive, cost-based threshold visit rate based on the average of each facility’s 1999 and 2000 reported base year costs, trended forward annually using the Medicare economic index. An “APG hold harmless calculation” will be done on a calendar year basis, based on actual claims data. The calculated APG payments per claim will be compared to the calculated PPS payment for APG claims, by location, to determine if the APG payment methodology paid less than the PPS rate. If the APG payment is lower, the calculated value of the hold harmless will be paid to the FQHC provider in a lump sum.

Similar to the supplemental wraparound (shortfall) reimbursement policy referenced above for fee-for-service (FFS) providers, any FQHC that “opts in” to APG reimbursement will continue to receive a Medicaid managed care (MMC) wraparound (shortfall) reimbursement reflecting the difference between actual MMC reimbursement, and the amount that the FQHC facility would have otherwise been reimbursed under the PPS rate, if the latter is higher. The provider should utilize the existing MMC FQHC shortfall rate codes.

Additional information regarding FQHCs is available on the DOH website at: [http://www.health.ny.gov/health\\_care/medicaid/rates/fqhc/](http://www.health.ny.gov/health_care/medicaid/rates/fqhc/).



## **6 Specialty Clinics**

This chapter of the manual provides billing guidance pertaining to specialty clinics and Federally Qualified Health Centers (FQHCs) within the APG reimbursement methodology.

### **6.1 Dialysis Services**

Providers must include all dialysis procedures, laboratory tests, and physician administered drugs (e.g., Epogen, Feraheme (Ferumoxytol), or Venofer) utilized during a dialysis session when submitting an APG claim for reimbursement.

#### Dialysis Rate Codes

Utilize rate code 1438 when seeking reimbursement for dialysis services for dually eligible Medicare/Medicaid members. Utilize either rate code 1438 or 1456 when seeking reimbursement for dialysis services for Medicaid only members. Claims submitted using rate code 1456 for dually eligible Medicare/Medicaid members may result in claims being incorrectly adjudicated, resulting in reduced APG reimbursement.

### **6.2 HIV Designated AIDS Centers (HIV DAC)**

A provider may seek reimbursement via the APG reimbursement methodology for all medically necessary HIV services rendered in an Article 28 setting. Providers should utilize the applicable OPD or D&TC APG rate codes when seeking reimbursement for HIV counseling and/or testing services.

#### HIV Counseling

A provider may seek reimbursement for HIV counseling within APGs. HIV counseling is designed to make a reimbursement via the “Procedure Based Weight” file instead of mapping to the standard APG. Providers must report the code that most closely corresponds with the amount of counseling time rendered to the member.

- 99401 - Preventive counseling, individual, approximately 15 minutes
- 99402 - Preventive counseling, individual, approximately 30 minutes
- 99403 - Preventive counseling, individual, approximately 45 minutes
- 99404 - Preventive counseling, individual, approximately 60 minutes

A provider may seek reimbursement for a separate E&M visit that is rendered on the same date of service (DOS) for the member whether the clinic visit was related to the patient’s HIV disease or not. For example, if the patient has a visit with a physician and as part of the E&M visit the physician provides appropriate HIV counseling, only the E&M can be billed. However, if the physician doesn’t provide counseling, but the patient has a separate encounter with an HIV counselor, then both services can be billed if documented in the chart as two distinct services.

Additional information regarding HIV/AIDS Counseling and Testing Services is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/docs/reimbursement\\_hiv\\_aids\\_counseling\\_testing.pdf](https://www.health.ny.gov/health_care/medicaid/rates/apg/docs/reimbursement_hiv_aids_counseling_testing.pdf).

### **6.3 Indian Health Centers**

Medicaid services provided to Native Americans living on reservations by federally recognized Tribal Clinics that are designated as an Indian Health Service (IHS) provider are exempt from the APG reimbursement methodology. The New York State Department of Health (Department) reimburses IHS providers based on an all-inclusive Medicaid rate in accordance with State Plan Amendment #99-39, which states that Tribal 638 outpatient facilities “are to be paid using the outpatient per visit rate published in the Federal Register.” However, Tribal Clinics with the Department’s Article 28 certification, which serve non-native American Medicaid beneficiaries, are required to submit claims for this patient population using the APG payment methodology, which calculates a payment based on the ICD-10 diagnosis codes and CPT/HCPCS procedure codes as provided on the claim.

## **7 APG Contact Information**

Contact information, found on our webpage at the following link, may be utilized to obtain additional information relative to the APG reimbursement methodology pertaining to Article 16 (OPWDD), Article 28 (DOH), Article 31 (OMH), and Article 32 (OASAS) facilities:

[https://www.health.ny.gov/health\\_care/medicaid/rates/contacts/](https://www.health.ny.gov/health_care/medicaid/rates/contacts/)

## **8 APG Glossary**

**Ambulatory Patient Group (APG)** – APGs are a reimbursement classification system utilized for the reimbursement of the facility’s cost of outpatient care. The fundamental basis of reimbursement within APGs is the categorization of the contact between the patient and the health care professional. The contact could be categorized by either a procedure, a medical evaluation and management (E&M), or an ancillary service. For each type of interaction, a prospective “weight” and price is established that includes all the routine services (e.g., blood tests, chest X-rays, etc.) associated with the visit and/or procedure. The cornerstone premise of the APG methodology is that if the costs for all the routine services rendered during a visit or a procedure were included in the reimbursement made to the facility; then there would exist a financial incentive to control the volume and frequency of the services rendered to the patient. Thus, a homogeneous pattern of resource utilization is an essential characteristic within the APG reimbursement methodology.

**Ancillary Tests and Procedures** – Ancillary tests and procedures are services ordered to assist in the patient’s diagnosis or treatment.

**APG Fee Schedule** - There are certain procedures within APGs that are reimbursed through the APG Fee Schedule. Procedures assigned to the APG Fee Schedule recognize the submission of units and are exempt from APG logic, such as significant procedure consolidation, and discounting.

The APG “Fee Schedule” is available on the DOH website at:

[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm)

**APG Weight** – APG “weight” is based on the resource intensity relative to all other APGs. The APG “weight” is a percentage used to reduce or increase the procedure’s reimbursement, depending on the APG grouper’s evaluation of the service line, resulting in the final “weight” for the procedure. The final “weight” for a given visit is multiplied by a provider-associated base rate as part of the APG reimbursement calculation. A single claim can be assigned multiple APGs, each of which carries its own “weight,” depending on procedure codes, modifiers, and in some cases, diagnosis codes.

The APG “Weights” list is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm).

**APG Software System** – APGs are classified and reimbursed using a software developed and published by 3M Health Information Systems (3M). The 3M “Grouper Pricer” software is used to

apply any appropriate grouping, bundling, packaging, and discounting logic in order to calculate a final APG weight, and allowed reimbursement amount. Each procedure and diagnosis coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**APG Types** - The APG reimbursement methodology classifies and assigns any procedure code submitted to Medicaid for reimbursement into these main categories: significant procedure, medical visit, ancillary procedure classification, incidental, or unassigned. The reimbursement under APGs is driven by this classification methodology.

**Base Rates** – A base rate is the dollar value assigned to the rate code used to determine the total allowable Medicaid APG reimbursement. The calculation of APG base rates are dependent on various factors including, but not limited to the following:

- Type of provider and service;
- Region – Downstate, upstate, statewide; and
- Case mix, visit volume, existing payment and target investment.

The “Base Rates” list is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm).

**Bundling/Packaging** - The 3M “Grouper Pricer” utilizes the APG reimbursement methodology logic to “Bundle” or “Package” certain ancillary and/or drug services into the reimbursement for the related significant procedure or medical visit. The related low level, inexpensive, and/or frequently provided ancillaries or drug services are included in the APG reimbursement for the significant procedures or medical visits they are associated with, rather than being reimbursed separately. However, other ancillary services, particularly those that are expensive or infrequently performed (such as MRI guidance for surgical procedures), are paid as separate ancillary APGs.

Medical visits are also designed to “Bundle” or “Package” with significant procedures as well, unless specifically identified not to do so in the regulations. When certain significant procedures are performed on the same day as a medical visit, no packaging would occur, and the provider would receive reimbursement for both the medical visit, and the significant procedure. For example, medical visits will not be required to “Bundle” or “Package” with the following procedures:

- High intensity ancillary procedures (e.g., mammograms, MRIs, CAT scans, etc.)
- Dental procedures
- Physical, speech and occupational therapy
- Counseling services

The “Packaged Ancillaries in APGs” list is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/uniform\\_packaging.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/uniform_packaging.htm).

**Capital Add-On** – Capital Add-Ons are a per-visit additional reimbursement automatically added to the reimbursement of an APG claim based on a facility’s cost reports provided to the NYSDOH. This add-on is applicable to allowable medical visits and significant procedures. In some cases, the APG reimbursement itself may cover the allowable capital cost. Capital add-ons

are computed on a provider-specific basis, except for those capital add-ons applicable to hospital-based ambulatory surgery centers and free-standing ambulatory surgery centers, which are computed on a peer group basis.

The “Capital Add-ons” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/apg/baserates.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm).

**Case Mix Index** – The actual or estimated average final APG weight for a defined group of APG visits.

**Current Procedural Terminology – Fourth Edition (CPT-4)** – The systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 and HCPCS are maintained by the American Medical Association and the federal Centers for Medicare and Medicaid Services and are updated annually.

**Diagnostic and Treatment Center (D&TC)** - Ambulatory services provided in a clinic that is certified under Article 28.

**Discounting** – When multiple significant and/or other procedures are performed or when the same ancillary service is performed multiple times, a discounting of the APG reimbursement rates can be applied. Discounting refers to a reduction in the standard reimbursement rate for an APG. Discounting recognizes the marginal cost of providing a second procedure to a patient during a single visit, which is less costly than providing the procedure by itself. For example, discounting could compensate for the reduced cost per procedure of doing multiple significant procedures at the same time.

The standard rate of discounting within the APG reimbursement methodology is 50%. However, several APGs discount at a rate less than the 50% standard amount.

The “Non-50% Discounting APG” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/non-50\\_discounting\\_7-1-15.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/non-50_discounting_7-1-15.htm).

**Episode** – The “Episode” rate code is utilized to capture all of the medical visits and/or significant procedures that occur over the span of multiple dates of service. The “Episode” rate code is used to recognize the dates of service for the significant procedure and/or medical visit, including any associated ancillaries that are performed in preparation of or in follow-up to the significant procedure and/or medical visit. All dates submitted for reimbursement utilizing the “Episode” rate code will be considered a part of the same “Episode” regardless of the reported dates of service on the claim. Providers should report the actual dates of service for all of the procedures and/or services that are part of the “Episode.”

**Free-standing Ambulatory Surgery** – Surgery and related services provided in an ambulatory surgery center that is certified under Article 28.

**Grouper Pricer** – APGs are classified and reimbursed using a software developed and published by 3M Health Information Systems (3M). The 3M “Grouper Pricer” software is used to apply any appropriate grouping, bundling, packaging, and discounting logic in order to calculate a final APG weight, and allowed reimbursement amount. Each procedure and diagnosis coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**Grouping** – APGs group procedures together that share similar clinical characteristics, service level intensity, and resource utilization for the purposes of reimbursement. Each procedure code submitted for reimbursement on a claim is grouped or assigned to a specific APG using the logic by the 3M Grouper Pricer software. When evaluation and management (E&M) codes are processed, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis in order to calculate reimbursement.

Once the APG grouping logic has been applied, the claim is then subjected to any applicable consolidation, bundling/packaging, and/or discounting of multiple significant, medical and/or ancillary procedures.

**Hospital-Based Ambulatory Surgery** – Surgery and related services provided in an ambulatory surgery center that is owned by the hospital and operated by the hospital under its hospital license.

**Hospital-Based Clinic Services** – Ambulatory services provided in a clinic that is owned by the hospital and operated by the hospital under its hospital license.

**Hospital-Based Emergency Services** – Emergency and related services provided in an emergency department (ED) that is owned by the hospital and operated by the hospital under its hospital license.

**HCPCS Codes** – The Healthcare Common Procedure Coding System. A numeric coding system maintained by the American Medical Association (AMA) used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

**If Stand Alone, Do Not Pay (ISADNP)** – Procedures that map to either the “If Stand Alone, Do Not Pay APGs” and/or the “If Stand Alone, Do Not Pay Procedures” lists consist primarily of laboratory and radiology diagnostic tests, which are packaged/bundled globally into the APG reimbursement made to the facility for an associated significant procedure and/or medical visit. The procedures on either of the “ISADNP” lists do not qualify for a separate reimbursement on their own, or combined with other ISADNP procedures, under the APG reimbursement methodology.

The “If Stand Alone, Do Not Pay APGs” list, and the “If Stand Alone, Do Not Pay Procedures” list is available on the DOH website at:

[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/](https://www.health.ny.gov/health_care/medicaid/rates/methodology/).

**Incidental Procedures:** – An integral part of a medical visit usually associated with professional services being given to the patient. (Example: range of motion measurements).

**Inpatient-Only Services** – Procedures designated as “Inpatient-Only” procedures may not be reimbursed within APGs, as those procedures may not be performed in an outpatient setting.

**International Classification of Diseases Codes** – A comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnoses, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

**Medical Visit APG** – A medical visit is an encounter in which a patient receives medical treatment but does not have a significant procedure performed. Evaluation and management (E&M) codes are assigned to one of the medical visit APGs based on the primary diagnosis reported on the claim.

**Modifiers** – The use of a modifier(s) provides a means by which a provider can indicate a service or procedure has been altered by some specific circumstance(s). The “NYS APG Modifiers” list is a resource of APG modifiers. The list includes the modifier code, a short description of the code, the state agencies it applies to, effective date, applicable APGs, how the modifier may affect payment, and Medicaid Update article if available.

The “NYS APG Modifiers” list is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/modifiers.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers.htm).

**Never Pay APGs and Procedures** – A “Never Pay” service is not reimbursable within the APG reimbursement methodology. Any service that is carved out or groups to a “Never Pay” APG will result in a \$0 reimbursement on the service line.

The “Never Pay Procedures” and “Never Pay APGs” lists (formerly known as “Carve Out” List) are available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/apg\\_carve\\_out.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/apg_carve_out.htm).

**No Capital Add-On** – These are procedures designated by the NYSDOH in which no additional reimbursement or “Capital Add-on” is automatically added to the reimbursement of an APG claim. This occurs when a claim is submitted for reimbursement that consists entirely of services on the “No Capital Add-on APGs” list or the “No Capital Add-on Procedure” list.

The “No Capital Add-On APG” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on.htm).

The “No Capital Add-On Procedure” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/no\\_capital\\_add-on\\_procedures.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/no_capital_add-on_procedures.htm).

**Packaging/Bundling** – The 3M “Grouper Pricer” utilizes the APG reimbursement methodology logic to “Bundle” or “Package” certain ancillary and/or drug services into the reimbursement for the related significant procedure or medical visit. The related low level, inexpensive, and/or frequently provided ancillaries or drug services are reimbursed globally and are included in the APG reimbursement for the significant procedures or medical visits they are associated with, rather than being reimbursed separately. However, other ancillary services, particularly those that are expensive or infrequently performed (such as MRI guidance for surgical procedures), are paid as separate ancillary APGs.

The “Packaged Ancillaries in APGs” list is available on the DOH website at:  
[https://www.health.ny.gov/health\\_care/medicaid/rates/methodology/uniform\\_packaging.htm](https://www.health.ny.gov/health_care/medicaid/rates/methodology/uniform_packaging.htm).

**Peer Group** – A group of providers or services that share a common APG base rate. Peer groups may be established based on geographic region, types of services provided or categories of patients.

**Procedure Based Weight** – Procedure based weight is the “weight” assigned to a procedure, which determines the reimbursement instead of the “weight” assigned to the APG for that procedure. A procedure reimbursed in this manner will be reimbursed based on the “APG procedure-based weight” file. Procedure codes assigned to “procedure-based weight” file are designed to recognize the submission of units on the APG claim. The “procedure-based weight” and the number of units are used in the calculation of the APG reimbursement.

The APG “Procedure Based Weight” file is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/history\\_and\\_fee\\_schedule.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm)

**Rebasing** – The re-determination of the base rate amount or other applicable components of the final payment rate from more recent Medicaid cost report data as determined by the Commissioner.

**Region** – The Downstate Region will consist of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The Upstate Region will consist of all other counties in New York State.

**Significant Procedure APG** – A significant procedure is a procedure which constitutes the reason for the visit and dominates the time and resources expended during the visit.

**Significant Procedure Consolidation** – When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation is the consolidation of multiple related significant procedure APGs into a single APG for determining reimbursement. The significant procedure consolidation list is based on clinical judgment during the 3M product development. The significant procedure consolidation list identifies, for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure, can be performed with relatively little additional effort, and therefore are consolidated.



The “Significant Procedure Consolidation” list is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/bundling/2016/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/bundling/2016/index.htm).

**Statewide Base Rates** – Statewide Base Rate APGs do not reimburse differently based on the location where services were rendered. These services are paid uniformly across all regions in New York State.

The “Statewide Base Rate APGs” list is available on the DOH website at:  
[http://www.health.ny.gov/health\\_care/medicaid/rates/methodology/statewide\\_base\\_rate\\_apgs.htm](http://www.health.ny.gov/health_care/medicaid/rates/methodology/statewide_base_rate_apgs.htm)

**Visit** – The “Visit” rate code is utilized to capture all the APG services that are performed for a member on a single date of service. The “Visit” rate code recognizes each date of service submitted on a claim as a separate encounter.