Changes in APG Reimbursement

Effective January 1, 2010

Overview of APG Payment Changes for January 1, 2010

1. Visit-based rate codes will be eliminated (except for ambulatory surgery services).
2. Updated APG weights and revised base rates
3. New enhanced hospital MR/DD/TBI base rate paying a 20% bump for patients with RE code 95 or RE code 81.
4. Pharmacotherapy and chemotherapy classifications will expand from 5 to 6 levels (however, chemo drugs will continue to be carved out).

Overview of APG Payment Changes for January 1, 2010 (cont.)

5. A new “premium” drug APG was created comprising both pharmacotherapy and chemotherapy drugs. This APG, and its associated drugs, will be carved out of APGs and will be billable as ordered ambulatory.
6. APGs will recognize units of service for some PT, OT, and nutrition procedure codes, as well as crisis management, patient education (including services rendered by CDEs & CAEs), and health/behavioral assessments.

Overview of APG Payment Changes for January 1, 2010 (cont.)

7. Medical visits will not package with significant ancillaries (e.g., MRIs), dental procedures, PT, OT, speech, and counseling services and will instead pay at the line level. All significant ancillaries will become "if stand alone, do not pay" procedures.
8. Multiple same APG discounting (rather than consolidation) which currently applies to most dental services will be expanded to include dental sealants, OT, PT, speech, and most mental hygiene APGs.

Overview of APG Payment Changes for January 1, 2010 (cont.)

9. Genetic testing procedures will be carved out and paid using the ordered ambulatory services fee schedule.
10. The no-blend APG list will be expanded to include cardiac rehabilitation (which comes off the never pay APG list in January), developmental testing, crisis management, medication administration, and medication management.

Overview of APG Payment Changes for January 1, 2010 (cont.)

11. The following new APGs were created:
    - *Physical Therapy – Group*
    - *Speech Therapy – Group*
    - *Crisis Intervention*
    - *Medication Administration and Observation (primarily developed for MMTP, which will not move to APGs in January 2010)*
    - *Mental Hygiene Assessment*
    - *Mental Hygiene Screening and Brief Assessment*
12. Some procedures (e.g., provision of vision aids) will be paid based on procedure-specific weights rather than APG-specific weights.

Overview of APG Payment Changes for January 1, 2010 (cont.)

13. Capital add-on rules will change so that an add-on is paid for nearly all types of visits including those consisting entirely of ancillaries and dental examinations (currently, a capital add-on is not paid with ancillary only visits).
    - *However, a capital add-on will not be paid for visits consisting solely of medication administration, PT-group, speech-group, cardiac rehabilitation, immunization, and patient education.*

Additional Major Program & Policy Changes

1. Statewide Patient-Centered Medical Home Incentive Program (implementation on Federal approval).
2. Physician Carve Out policy effective for OPDs (scheduled for February 1, 2010 implementation).

New Episode-Based Payment Will Replace Visit-Based Payment

- Beginning January 1, 2010 OPDs and SBHCs must use new episode-based rate codes (1432 and 1450) for Medicaid patients. *Providers may continue to use visit based rate codes for dual eligible recipients.*
- Under episode pricing, the APG Grouper Pricer will view all procedures coded on a claim as being part of the same visit, regardless of the coded dates of service.
  - *Providers will no longer have to "reassign" the actual date of service for related ancillaries to the same date of service as the initial medical visit or procedure.*
- An episode is defined as all medical visits and/or significant procedures that occur on a single date of service, as well as any *associated ancillaries* that occurred on or after the date of the medical visit and/or significant procedure.

APG Billing Rate Codes
In Effect for January 2010

Service/Setting	Facility Type	Rate Codes - Effective January 1, 2010	
		Visit	Episode
Outpatient Department *	Hospital	~~1400~~	1432
OPD - MR/DD/TBI	Hospital	NA	1489
Ambulatory Surgery	Hospital	1401	NA
Emergency Room	Hospital	NA	1402
School Based Health *	Hospital	~~1444~~	1450
General Clinic *	DTC **	~~1407~~	1422
General Clinic - MR/DD/TBI *	DTC	~~1435~~	1425
Dental School *	DTC	~~1428~~	1459
Renal Clinic *	DTC	~~1438~~	1456
School Based Health *	DTC	~~1447~~	1453
Free-standing Surgery Center	DTC	1408	NA

Notes:

* Rate codes being eliminated will continue to be active through December 31, 2009.

** DTC Rate Codes will be effective September 1, 2009 (pending CMS approval), except codes 1453, 1456, and 1459 which are effective 10/1/2009.

Drug and Chemo Reclassifications for January 2010

CPT	Description	Current APGs	New 2010 APGs	Description
J0130	Abciximab injection	438	435	Class I Pharmacotherapy
J1245	Dipyridamole injection	435	436	Class II Pharmacotherapy
J1562	Vivaglobin, inj	435	436	Class II Pharmacotherapy
J2185	Meropenem	435	436	Class II Pharmacotherapy
J0210	Methyldopate hcl injection	435	436	Class II Pharmacotherapy
J2248	Micafungin sodium injection	438	436	Class II Pharmacotherapy
79005	Nuclear rx, oral admin	436	437	Class III Pharmacotherapy
Q4081	Epoetin alfa, 100 units ESRD	436	437	Class III Pharmacotherapy
J1573	Hepagam b intravenous, inj	436	438	Class IV Pharmacotherapy
J2820	Sargramostim injection	437	438	Class IV Pharmacotherapy
J2353	Octreotide injection, depot	438	439	Class V Pharmacotherapy
J0850	Cytomegalovirus imm IV /vial	439	440	Class VI Pharmacotherapy

CPT	Description	Current APGs	New 2010 APGs	Description
S0156	Exemestane, 25 mg	435	430	Class I Chemotherapy Drugs
S0187	Tamoxifen 10 mg	435	430	Class I Chemotherapy Drugs
J9380	Vincristine sulfate 5 MG inj	430	431	Class II Chemotherapy Drugs
J9291	Mitomycin 40 MG inj	432	431	Class II Chemotherapy Drugs
J1327	Eptifibatide injection	431	432	Class III Chemotherapy Drugs
J8520	Capecitabine, oral, 150 mg	430	432	Class III Chemotherapy Drugs
J9120	Dactinomycin injection	430	433	Class IV Chemotherapy Drugs
J9206	Irinotecan injection	434	433	Class IV Chemotherapy Drugs
J9170	Docetaxel injection	433	434	Class V Chemotherapy Drugs
J9261	Nelarabine injection	432	434	Class V Chemotherapy Drugs
J2278	Ziconotide injection	433	441	Class VI Chemotherapy Drugs
J9035	Bevacizumab injection	434	441	Class VI Chemotherapy Drugs

NOTE: The aforementioned are examples of drug reclassifications effective January 1, 2010. For a complete list consult the APG website.
http://www.nyhealth.gov/health_care/medicaid/rates/apg/

New Premium "Class VII" APG for Select Chemotherapy and Pharmacotherapy Drugs

- There will be a new "premium" drug APG, consisting of certain chemotherapy and pharmacotherapy drugs. **All drugs grouping to this class will be carved out of APGs and billable to the Ordered Ambulatory Fee Schedule.**

CPT	Description	Current APGs	New 2010 APGs	New 2010 APGs
J7311	Fluocinolone acetonide implt	437	442	CLASS VII COMBINED CHEMOTHERAPY & PHARMACOTHERAPY
J1458	Galsulfase injection	439		
J1785	Injection imiglucerase /unit	439		
J1300	Eculizumab injection	439		
J9300	Gemtuzumab ozogamicin inj	434		
J0180	Agalsidase beta injection	434		

New Mental Hygiene APGs

- All providers that bill using APGs will have access to the following APG groups:

APG	APG Description	APG Type Description
321	Crisis Intervention	Significant Procedure
322	Medication Administration & Observation *	
323	Mental Hygiene Assessment	
324	Mental Health Screening & Brief Assessment	
274	Physical Therapy, Group	
275	Speech Therapy & Evaluation, Group	

* This APG is primarily for Methadone Maintenance, which will not transition to APGs in January 2010.

New APG With Procedure Based Weights and APGs That Recognize Units of Service

- **To recognize significant cost differentials in a single service, some procedures will be paid based on procedure-specific weights rather than APG-specific weight, including the following types of services:**
  - *Select Mental Hygiene Services,*
  - *Physical Therapy (for units-based procedures),*
  - *Occupational Therapy (for units-based procedures), and*
  - *Crisis Management.*

Procedure-based Weights & Units of Service Features in Some APGs

All Procedure-Based and Units-Based APGs	
APG	**APG Description**
118	Nutrition Therapy
270	Occupational Therapy
271	Physical Therapy
272	Speech Therapy And Evaluation
310	Developmental & Neuropsychological Testing
312	Full Day Partial Hospitalization For Mental Illness
315	Counseling Or Individual Brief Psychotherapy
316	Individual Comprehensive Psychotherapy
317	Family Psychotherapy
320	Case Management & Treatment Plan Development - Mental Health Or Substance Abuse
321	Crisis Intervention
323	Mental Hygiene Assessment
426	Psychotropic Medication Management
427	Biofeedback And Other Training
428	Education - Individual
429	Education - Group
490	Incidental To Medical, Significant Procedure Or Therapy Visit

APG	APG Description	Payment Action Flag Description	HCPCS Code	HCPCS code description
118	Nutrition Therapy	Alternate Weight - Not Units Based	97804	Medical nutrition, group, each 30 min
			G0271	Group MNT 2 or more 30 mins
		Alternate Weight - Units Based	97802	Medical nutrition, indiv, each 15 min
			97803	Med nutrition, indiv, subseq, each 15 min
			G0270	MNT subs tx for change dx, each 15 min
270	Occupational Therapy	Alternate Weight - Units Based *	97532	Cognitive skills development, 15 min
			97533	Sensory integration, 15 min
271	Physical Therapy	Alternate Weight - Units Based *	97032	Electrical stimulation, 15 min
			97033	Electric current therapy, 15 min
272	Speech Therapy And Evaluation	Alternate Weight - Not Units Based	92607	Ex for speech device rx, 1hr
			92608	Ex for speech device rx addl

* For illustration purposes only. These APGs include additional procedures not shown in this table.

Medical Visits Will No Longer Package With Higher Intensity Significant Ancillaries

- Medical visits will no longer package with:
  - *more significant ancillaries (e.g., MRIs, mammograms, CAT scans, etc.);*
  - *dental procedures;*
  - *PT, OT, and speech therapies; and,*
  - *counseling services.*
  - In these cases, a coded medical visit will separately pay at the line level.

Revised "If Stand Alone, Do Not Pay" List

- New additions to the "if stand alone, do not pay" list for January 2010 are as follows:

New If Stand Alone Do Not Pay APGs for January 2010		
APG Type	APG	APG Desc
Significant Procedure	118	Nutrition Therapy
Significant Procedure	281	Magnetic Resonance Angiography - Head And/Or Neck
Significant Procedure	282	Magnetic Resonance Angiography - Chest
Significant Procedure	283	Magnetic Resonance Angiography - Other Sites
Significant Procedure	292	Mri- Abdomen
Significant Procedure	293	Mri- Joints
Significant Procedure	294	Mri- Back
Significant Procedure	295	Mri- Chest
Significant Procedure	296	Mri- Other
Significant Procedure	297	Mri- Brain
Ancillary	373	Level I Dental Film
Ancillary	374	Level II Dental Film
Ancillary	375	Dental Anesthesia
Drug	440	Class VI Pharmacotherapy

New (Additional) “No Blend APGs”

- The following new APGs will pay entirely based on the APG payment methodology and no existing payment will be factored into the operating component of the rate.

APG	APG Description	APG Type
94	Cardiac Rehabilitation	Significant Procedure
310	Developmental and Neuropsychological Testing	Significant Procedure
312	Full Day Partial Hospitalization for Mental Illness	Per Diem
321	Crisis Intervention	Significant Procedure
322	Medication Administration and Observation	Significant Procedure
426	Medication Management	Ancillary

Additional Significant Program & Policy Changes

Statewide Patient-Centered Medical Home Incentive Program

- This initiative will incentivize providers for developing patient-centered medical homes to improve health outcomes through better coordination and integration of patient care.
- New York Medicaid has chosen to adopt medical home standards consistent with the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® – Patient-Centered Medical Home Program (PPC-PCMH™).
- The PPC-PCMH™ is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement.
- A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, providers and staff.
- Care is also facilitated by registries, information technology, health information exchange and other means to ensure that patients obtain the proper care in a culturally and linguistically appropriate manner.

Statewide Patient-Centered Medical Home Incentive Program (cont.)

To be recognized as a medical home, providers need to demonstrate they can meet at least five of the following 10 criteria (i.e. achieve a minimum of 25 points out of 100 possible to attain the first of three levels of recognition):

- *Written standards for patient access and patient communication;*
- *Use of data to show standards for patient access and communication are met;*
- *Use of paper or electronic charting tools to organize clinical information;*
- *Use of data to identify important diagnoses and conditions in practice;*
- *Adoption and implementation of evidence-based guidelines for three chronic conditions;*
- *Active patient self-management support;*
- *Systematic tracking of test results and identification of abnormal results;*
- *Referral tracking, using a paper or electronic system;*
- *Clinical and/or service performance measurement, by physician or across the practice; and*
- *Performance reporting, by physician or across the practice.*

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	**4**
B. **Uses data to show it meets its standards for patient access and communication****	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	**6**
E. **Uses data to identify important diagnoses and conditions in practice****	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. **Actively supports patient self-management****	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. **Tracks referrals using paper-based or electronic system****	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. **Measures clinical and/or service performance by physician or across the practice****	**3**
B. Survey of patients' care experience	3
C. **Reports performance across the practice or by physician ****	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

NCQA Measuring quality. Improving health care

1

Statewide Patient-Centered Medical Home Incentive Program (cont.)

- There are three levels of medical home recognition that providers can achieve based on the following NCQA scoring scale:

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements do not Qualify.

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Statewide Patient-Centered Medical Home Incentive Program (cont.)

- Medicaid FFS claims with appropriately coded Evaluation and Management (E&M) codes 99201-99205, 99211-99215, or Preventive Medicine codes 99381-99386, 99391-99396 will be eligible for one of three enhanced payment levels (shown below), commensurate with the level of NCQA recognition received by the provider.

Medical Home Pervisit Payment Add-ons

Setting	Level I	Level II	Level III
Article 28 clinics	$5.50	$11.25	$16.75
Office-based practitioners*	$7.00	$14.25	$21.25

* Includes physicians and registered nurse practitioners

- NCQA recognized providers that participate in Medicaid and Family Health Plus health plans will receive details on the payment amounts they can expect for services provided to plan enrollees.

Physician Carve Out Policies for OPDs

- Reimbursement for physician professional services provided by hospital OPDs will be carved out of APGs beginning February 1, 2010.
  - Note, there will be no change to current Medicaid policy which disallows payment for interns and/or residents, yet allows payment for supervisors and/or teaching physicians under specified conditions.

Supporting Materials

- The following is available on the DOH website (http://www.nyhealth.gov/health_care/medicaid/rates/apg/)
  - *Provider Manual* (*http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual*)
  - *PowerPoint Presentations*
  - *APG Documentation*
    - *APG Types, APG Categories, APG Consolidation Logic*
  - *Revised Rate Code Lists*
  - *Uniformly Packaged APGs*
  - *Inpatient-Only Procedure List*
  - *Never Pay and If Stand Alone Do Not Pay Lists*
  - *Carve-Outs List*
  - *List of Rate Codes Subsumed in APGs*
  - *Paper Remittance*
  - *Frequently Asked Questions*
  - *Ambulatory Surgery List*

Contact Information

- Grouper / Pricer Software Support

  3M Health Information Systems

  - *Grouper / Pricer Issues 1-800-367-2447*
  - *Product Support 1-800-435-7776*
  - *http://www.3mhis.com*

- Billing Questions

  Computer Sciences Corporation

  - *eMedNY Call Center: 1-800-343-9000*
  - *Send questions to: eMedNYProviderRelations@csc.com*

- Policy and Rate Issues

  New York State Department of Health

  Office of Health Insurance Programs

  Div. of Financial Planning and Policy 518-473-2160

  - *Send questions to: apg@health.state.ny.us*