APG Implementation

Ambulatory Patient Groups (APGs) and Ancillary Lab/Radiology Services

September 3, 2009

Objectives

- Provide update on APG Implementation in D&TCs
- Review general APG payment and policy rules
- Review APG policy on ancillary laboratory and radiology services.
- Review billing guidance for ancillary laboratory and radiology services claims.
- Identify APG resource materials for providers.
- Answer questions.

Webinar Ground Rules

Please -

- **Do Not Put Conference Call on Hold**
- Place Phone on Mute During Presentations
- Hold Questions Until the Q and A Period

Speakers

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Status of Implementation

- APGs were implemented in hospital-based outpatient clinics and ambulatory surgery centers on December 1, 2008 and emergency departments on January 1, 2009.
- APGs will be implemented in free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers upon CMS approval.
- September 1, 2009 has been requested as the implementation date for diagnostic & treatment center clinics.
- Impact letters have been sent to DTCs.
- We will keep you posted on the approval status, please continue to check the website for the implementation date as well as billing guidance.

Status of Implementation (cont.)

- During this time DOH has:
  - Refined policies
  - Updated the provider manual
  - Provided training
  - Developed and updated website
  - Responded to questions from providers via APG mail log.
- DTC providers should be:
  - *Preparing to use new rate codes and accurate CPT and ICD-9 coding.*
  - *Submit test claims to eMedNY.*

Background

- Existing Medicaid outpatient rate methodologies are broken, most clinic rates and ambulatory surgery rates are outdated.

- Most DTC rates have been frozen since 1995 (except for FQHCs).

- By failing to keep pace with the cost of care and medical advances, the current ambulatory care rates do not appropriately pay providers who deliver evidenced-based, state of the art care.

Reform Objectives

- **Encourage** migration of services from inpatient to ambulatory/primary care settings.
- **Invest** in ambulatory care to provide more adequate reimbursement.
- **Develop** a new payment system to pay more for higher cost services and less for lower cost services.
- **Ensure** better payment homogeneity for similar/comparable services across ambulatory care settings.
- **Improved** clarity and transparency of payment structure and methodology.
- **Frequent** payment updates to recognize medical advances and changes in cost of service delivery.
- **Support** evidenced-based, state-of-the-art healthcare.

What are APGs?

- A classification system designed to explain the amount and type of resources used in ambulatory visits that:
  - *Predicts the average pattern of resource use for a group of patients by combining procedures, medical visits and/or ancillary tests that share similar characteristics and resource utilization;*
  - *Provides greater reimbursement for higher intensity services and less reimbursement for low intensity services; and*
  - *Allows more payment homogeneity for comparable services across all ambulatory care settings (e.g., outpatient department and diagnostic and treatment centers).*

APG's Clinical Strengths

- Superior to "Threshold Visit" and outdated PAS rates.
- Payment varies based on service intensity.
- Payment homogeneity for comparable services across ambulatory care settings
  - relative payment "weights" do not vary by setting.
  - base rates do vary to recognize differing cost structures between settings.
- Emphasizes diagnosis and procedures over service volume.

APG's Methodological Advantages

- Recognized and tested payment system.
- Enables prospective pricing for Ambulatory Care.
- Grouping and payment logic similar to DRGs.
- Uses standard HIPAA-compliant code sets (HCPCS and ICD-9 codes)
- Uses current HIPAA compliant claim formats.
- Greater clarity and transparency of payment structure and methodology.
- Features more frequent payment updates to:
  - *Better acknowledge the impact of medical advances, and*
  - *Accommodate changes in service delivery patterns.*
- Four year transition using "blend" to allow time to adjust to new payment methodology.

Building a Sound Primary Care Infrastructure

- **The 2008-09 Budget Began Ambulatory Care Reform**
  - *New outpatient payment method (APG) replaces per-visit payment system*
  - *$178 million invested in hospital clinics, ambulatory surgery and ER*
  - *Additional investments in D&TCs and physicians*
  - *Enhancements for weekend/evening hours, and diabetes/asthma educators*
- **The 2009-10 Budget Builds on these Reforms**
  - *Increases investment in hospital and community clinic rates*
    - ✓ *Medicaid will cover approximately 90% of average hospital clinic costs*
    - ✓ *Medicaid will cover approximately 90% of average D&TC costs*
  - *Increases investment in physician fees*
    - ✓ *Payments to physicians will increase by 80% over 2007 levels*
  - *Enhances payments for providers that meet medical home standards*
  - *Coverage for smoking cessation, cardiac rehabilitation, and screening and counseling for substance abuse patients in ER*

Provider Billing Changes

- **New APG Grouper Access Rate Codes (Visit/Episode)**
  - Effective upon APG Implementation
    - DTC General Clinic Rate Code – 1407 / 1422
    - DTC Dental Rate Code – 1428 / 1459
    - DTC Renal Rate Code – 1438 / 1456
    - DTC MR/DD/TBI Patient - 1435 / 1425
    - Free-Standing Ambulatory Surgery Rate Code - 1408
    - School Based Health 1447 / 1453

- **Most Existing Rate Codes will become obsolete as of APG effective date.**

- **For billing or adjusting for DOS prior to APG implementation, use old rate code.**

THREE PRIMARY TYPES OF APGs

- **SIGNIFICANT PROCEDURE**
  - *A procedure which constitutes the reason for the visit and dominates the time and resources expended during the visit. Examples include: excision of skin lesion, stress test, treating fractured limb.*
- **MEDICAL VISIT**
  - *A visit during which a patient receives medical treatment (normally denoted by an E&M code), but did not have a significant procedure performed. E&M codes are assigned to one of the 181 medical visit APGs based on the diagnoses shown on the claim (usually the primary diagnosis).*
- **ANCILLARY TESTS AND PROCEDURES**
  - *Ordered by the primary physician to assist in patient diagnosis or treatment. Examples include: immunizations, plain films, laboratory tests.*

APG Payment Definitions

- **Consolidation or Bundling**
  - *The inclusion of payment for a related procedure into the payment for a more significant procedure provided during the same visit.*
    - *CPT codes that group to the same APG are consolidated.*
- **Packaging**
  - *The inclusion of payment for related medical visits or ancillary services in the payment for a significant procedure.*
    - *The majority of "Level 1 APGs" are packaged.*
      (i.e. pharmacotherapy, lab and radiology)
    - *Uniform Packaging List is available online at the DOH APG website.*
- **Discounting**
  - *A discounted payment for an additional, but unrelated, procedure provided during the same visit to acknowledge cost efficiencies.*
    - *If two CPT codes group to different APGs, 100% payment will be made for the higher cost APG, and the second procedure will be discounted at 50%.*

Sample APG / HCPCS Crosswalk

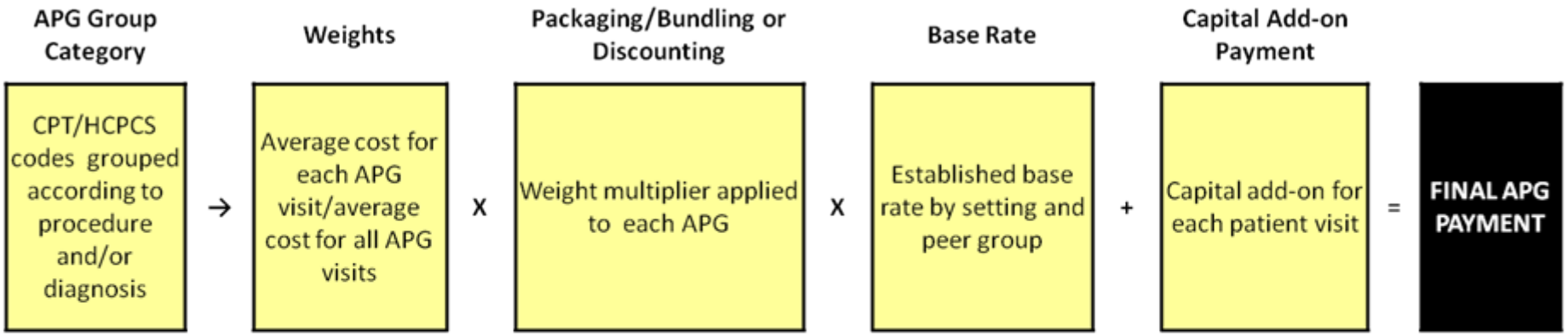
APGs	APG Descp	HCPCS Code	HCPCS Descp
84	DIAGNOSTIC CARDIAC CATHETERIZATION	93501	Right heart catheterization
		93510	Left heart catheterization
		93511	Left heart catheterization
		93514	Left heart catheterization
		93524	Left heart catheterization
		93526	Rt & Lt heart catheters
		93527	Rt & Lt heart catheters
		93528	Rt & Lt heart catheters
		93529	Rt, lt heart catheterization
		93530	Rt heart cath, congenital
		93531	R & l heart cath, congenital
		93532	R & l heart cath, congenital
		93533	R & l heart cath, congenital
		S8093	CT angiography coronary

Sample APGs and Weights

EAPG	EAPG Name	Type	Weight
030	LEVEL I MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	8.3113
031	LEVEL II MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	10.3281
032	LEVEL III MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Significant Procedure	13.1830
040	SPLINT, STRAPPING AND CAST REMOVAL	Significant Procedure	1.6166
084	DIAGNOSTIC CARDIAC CATHETERIZATION	Significant Procedure	12.6153
112	PHLEBOTOMY	Significant Procedure	0.9094
116	ALLERGY TESTS	Significant Procedure	1.9176
271	PHYSICAL THERAPY	Significant Procedure	0.3497
280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY	Significant Procedure	10.7456
315	COUNSELING OR INDIVIDUAL BRIEF PSYCHOTHERAPY	Significant Procedure	0.3521
396	LEVEL I MICROBIOLOGY TESTS	Ancillary	0.1687
397	LEVEL II MICROBIOLOGY TESTS	Ancillary	0.2270
413	CARDIOGRAM	Ancillary	0.1870
414	LEVEL I IMMUNIZATION AND ALLERGY IMMUNOTHERAPY	Ancillary	0.1155
471	PLAIN FILM	Ancillary	0.6885
527	PERIPHERAL NERVE DISORDERS	Medical Visit	0.7120
562	INFECTIONS OF UPPER RESPIRATORY TRACT	Medical Visit	0.6893
575	ASTHMA	Medical Visit	0.9150
599	HYPERTENSION	Medical Visit	0.6952
826	ACUTE ANXIETY & DELIRIUM STATES	Medical Visit	0.9012
808	VIRAL ILLNESS	Medical Visit	0.9073

APG Payment Methodology

APG PAYMENT CALCULATION OVERVIEW



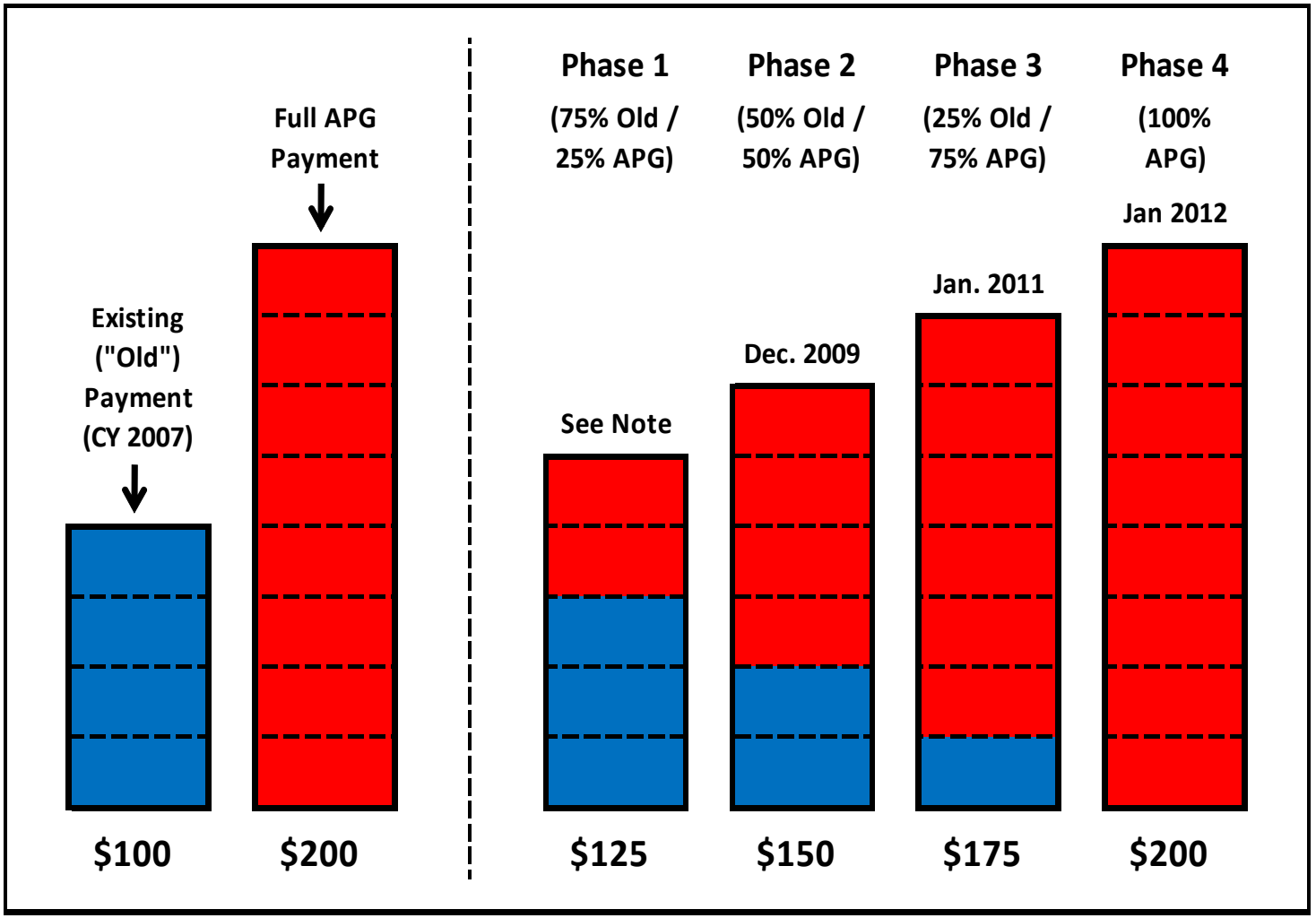
Weight Multiplier (Consolidating or Discounting Logic)

- 100% for primary (highest-weighted) APG procedure
- 100% unrelated ancillaries
- 150% for bilateral procedures
- 50% for discounted lines (unrelated significant procedures performed in a single visit).
- 0% for bundled/consolidated lines (related ancillaries are included in the APG significant procedure payment)

Phasing and Blending

- Phasing: APG payments will be phased-in over time through blending
- Blending: The Medicaid payment for a visit will include a percentage of the payment amount based on APGs and a complementary percentage of the payment amount based on the average facility clinic rate in 2007 as defined by DOH.

Hospital OPD and DTC Transition and "Blend"



Note: Blend goes into effect on 12/1/08 for Hospital OPDs and 9/1/09 for Free-Standing Clinics and Ambulatory Surgery.

Base Rates

- Base rates are established for peer groups
  - *e.g. DTC, hospital OPD , hospital ED, free standing ambulatory surgery centers, etc.*
- Within each peer group there are downstate and upstate regions that have differing rates
- Peer group base rates are calculated based on case mix, visit volume, cost, and targeted investment.
- Base rates represent a conversion factor for multiplication by APG weights on a claim to arrive at the APG payment amount.

APG Base Rate Regions

- Downstate - New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange
- Upstate - The rest of the State

Base Rate Variables

- Case Mix Index (CMI)
- Coding Improvement Factor (CIF)
- Visit Volume
- Targeted Expenditure Level
  - *Base Year Expenditures*
  - *Investment*
- Reported Provider Cost by Peer Group (for scaling of investments)

Case Mix Index

- Definition - The average allowed APG weight per visit for a defined group of visits (based on peer group and time period of claims).

Coding Improvement Factor

- A numeric value used to adjust for the fact that the coding of claims subsequent to the implementation of APGs will become more complete and accurate (CMIs will increase).

Base Rate Formula

(for initial implementation)

$$\frac{\text{Base Year Expenditures} + \text{Investment}}{\text{CMI} \times \text{CIF} \times \text{Base Year Visits}}$$

Payment Example 1- Medical Visit (Asthma)

(All procedures are grouped based on the same Date of Service)

APG Base Rate:	**$184.77**	**Rate Code:**	**1407 (DTC General Clinic)**
Existing Payment for Blend:	**$135.18**	**Region:**	**Downstate**
Blend Percentage (APG):	**25%**	**Primary Dx Code (Description):**	**49390 (Asthma NOS)**

Px Code	Procedure Description	APG	APG Description	Payment Action	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
99213	Office/outpatient visit, est	575	Asthma	Full payment	100%	0.9150	$ 169	$ 42	$ 101	$ 24	$ 167
82565	Assay of creatinine	400	Level I Chemistry Tests	Packaged	0%	0.0000	-	-	-	-	-
71020	Chest x-ray	471	Plain Film	Packaged	0%	0.0000	-	-	-	-	-
TOTALS						0.9150	$ 169	$ 42	$ 101	$ 24	$ 167

Note: APG weights and base rates shown are for illustrative purposes only.

Payment Example 2- Medical Visit (HIV)

(All procedures are grouped based on the same Date of Service)

APG Base Rate:	**$184.77**	**Rate Code:**	**1407 (DTC General Clinic)**
Existing Payment for Blend:	**$135.18**	**Region:**	**Downstate**
Blend Percentage (APG):	**25%**	**Primary Dx Code (Description):**	**42 (Human immuno virus dis)**

Px Code	Procedure Description	APG	APG Description	Payment Action	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
99213	Office/outpatient visit, est	881	Aids	Full payment	100%	0.9932	$ 184	$ 46	$ 71	$ 24	$ 140
85025	Complete cbc w/auto diff wbc	408	Level I Hematology Tests	Packaged	0%	0.0000	-	-	-	-	-
80076	Hepatic function panel	403	Organ Or Disease Oriented Panels	Full payment	100%	0.3618	67	17	26	-	43
90740	Hepb vacc, ill pat 3 dose im	416	Level III Immunization	Full payment	100%	0.4323	80	80	-	-	80
36415	Routine venipuncture	457	Venipuncture	Full payment	100%	0.0675	12	3	5	-	8
TOTALS						**1.8548**	**$ 343**	**$ 146**	**$ 101**	**$ 24**	**$ 271**

Note: APG weights and base rates shown are for illustrative purposes only.

For this visit, the following carved-out services were billed to the Laboratory Fee Schedule: 87900 ($80), 87901 ($350), and 87903 ($675).

Payment Example 3- Medical Visit (Family Planning)

(All procedures are grouped based on the same Date of Service)

APG Base Rate:	**$184.77**	**Rate Code:**	**1407 (DTC General Clinic)**
Existing Payment for Blend:	**$135.17**	**Region:**	**Downstate**
Blend Percentage (APG):	**25%**	**Primary Dx Code (Description):**	**9815 (Gc cervicitis (acute))**

Px Code	Procedure Description	APG	APG Description	Payment Action	Payment Percent	Allowed Weight	Full APG Payment	APG Portion of Blend	Existing Payment Portion of Blend	Add-on Payment	Total Payment
57505	Endocervical curettage	196	Level I Female Reproductive Procedures	Full payment	100%	4.8933	$ 904	$ 226	$ 97	$ 24	$ 347
87490	Chylmd trach, dna, dir probe	394	Level I Immunology Tests	Packaged	0%	0.0000	-	-	-	-	-
87590	N.gonorrhoeae, dna, dir prob	397	Level II Microbiology Tests	Full payment	100%	0.2270	42	10	4	-	15
88305	Tissue exam by pathologist	390	Level I Pathology	Packaged	0%	0.0000	-	-	-	-	-
99213	Office/outpatient visit, est	491	Medical Visit Indicator	Packaged	0%	0.0000	-	-	-	-	-
TOTALS						**5.1203**	**$ 946**	**$ 237**	**$ 101**	**$ 24**	**$ 362**

Note: APG weights and base rates shown are for illustrative purposes only.

Ancillary Policy

APG Payment Policy For Ancillary Laboratory and Radiology Services

- The overriding goals of APGs are to:
  - Promote a medical home for the patients.
  - Ensure continuity of patient care.
  - Promote efficiency in the payment model.
- To promote these goals, Medicaid payment is made to the clinic for ancillary laboratory and radiology services ordered for their patient.
  - Including laboratory/radiology services provided by outside vendors subsequent to the clinic visit.

Diagnostic & Treatment Center Clinic Billing Policy

- Upon APG implementation, lab or radiology services provided by the D&TC clinic or those referred to an outside provider are the fiscal responsibility of the D&TC even in the absence of a contractual relationship between the parties.
- The medical visit and/or significant procedure as well as all ancillary lab and radiology services must be reported on the APG claim.
- The laboratory/radiology provider may not bill Medicaid for these services.

The Ancillary Service Provider Will Bill the Ordering Clinic for Lab or Radiology Services

For example:

- Practitioner in Clinic A orders a lab test or radiology service for a fee-for-service Medicaid patient . The clinic is billing APG rate code 1407 APG visit or 1422 episode visit.
- Clinic A does not provide service on site.
- The patient goes to Provider B which is a separate hospital, lab or radiology group to receive the service.
- Clinic A will need to make arrangements to pay Provider B for the delivery of the service.
- The ancillary provider can not bill Medicaid fee-for-service.

Patient Referral to Ancillary Service Providers

- Clinics may choose to contract with laboratory and radiological vendors for ancillary services.
- However, the recipient cannot be required by the clinic to obtain ordered ancillary services from contracted vendors.
- A clinic can, however, make an appointment for the patient with the lab/radiology ancillary services provider without giving the patient the prescription/order.
- The clinic is responsible for paying the individual or entity providing the ancillary service even in the absence of a contractual relationship between the parties.
  - Payment amounts for ancillary services are negotiated between the ordering clinic and ancillary services provider.

Diagnostic & Treatment Center Clinics are responsible for:

- Advising outside lab and radiology service providers that the ordered test is part of a clinic visit subject to APG reimbursement.
- Instructing the lab/radiology provider that the ordering clinic should be billed for the ancillary service.
- Reimbursing the laboratory/radiology provider for all ancillary procedures ordered as part of a clinic visit and which have been provided to their patient.

Billing the Professional and Technical Component

- As with the clinic threshold rate, the physician professional component is always included in the APG payment to the D&TC.
  - There are two exceptions to this policy;
    - Ambulatory Surgery- The professional component should be billed by the attending physician (surgeon, anesthesiologist) using the Medicaid physician fee schedule.
    - The professional component for ancillary radiology services should be billed by the radiologist using the Medicaid physician fee schedule when the radiology procedure is being done on an ordered ambulatory patient. (i.e., The patient is referred from either an Article 28 clinic or community physician)
      - The D&TC must bill the radiology technical component to the referring clinic.

Lab Tests Carved Out of APGs

- The following lab tests are carved out of APGs. These tests may continue to be billed to eMedNY using the laboratory fee schedule. These tests are:
  - Lead screen (e.g., CPT code 83655)
  - HIV viral load testing (e.g., CPT code 87539)
  - HIV drug resistance tests (e.g., CPT code 87900,87901,87903,87904,87999)
  - Hep C virus, genotype tests (e.g., CPT code 87902)

Additional Lab Test Carve Outs

Recurring Lab Tests

- White Blood Cell Test for Clozaril (CPT 85004)
- Prothrombin Time for Coumadin (CPT 85610)
  - The above two blood tests should be billed using the laboratory fee schedule.
    - Note: OHIP is reviewing other lab tests related to routine drug monitoring that may potentially be carved out of APGs.

Urine Pregnancy Test (CPT 81025)

- Applicable when performed in a family planning clinic (as defined by DOH) and no E&M code is billed.
- Patient sees a RN or LPN for family planning counseling and the pregnancy test.
- An APG claim should not be billed to Medicaid.
- Pregnancy test should be billed using the laboratory fee schedule.

Ambulatory Surgery
Pre and Post Surgical Lab Tests

- Pre-surgical lab testing
  - If the patient is a “clinic patient” and the pre-surgical lab testing has been ordered by the clinic practitioner, the pre-surgical lab tests should be included on the clinic APG claim.
  - If the pre-surgical lab tests are ordered by the surgeon or a physician not associated with the clinic, e.g., community physician, the lab tests should be billed using the ordered ambulatory laboratory fee schedule.
- Post surgical testing (e.g., pathology)
  - All post-surgical lab tests are not included in the ambulatory surgery APG payment and should be billed using the laboratory fee schedule.

Radiation Therapy

- Radiation therapy may occur on a recurring basis as a stand-alone service.
  - e.g., radiation oncology, radiation treatment management and delivery (CPT codes 77261-77499)
- Radiation therapy is not considered an ancillary service, so the ancillary APG payment policy does not apply to radiation therapy.
- Radiation therapy may be billed as a stand-alone procedure using the date of service when the treatment is provided.

APG Visit Rate Code 1407
&
APG Episode Rate Code 1422

Diagnostic & Treatment Center Clinic Billing Options

- Initially there will be two options for billing APGs and associated ancillaries.
- APG Visit Payment
  - Use rate code 1407.
  - “Reassign” the actual date of service for the ancillary to the same date of service of the medical visit or procedure.
  - Ancillary will not be viewed by the payment system as a stand alone.
    - Note: this rate code will be end dated December 31, 2009.
  - APG Episode Payment
  - Use rate code 1422.
  - Report the actual dates of service for E&M/significant procedure and dates of service for each associated lab/radiology ancillary.

D&TCs APG Visit Payment
APG Rate Code 1407

- The date of service reported on the claim for all lab and radiology procedures should be the same date as the medical visit/significant procedure.
- The “from/through” date in the header should encompass the dates of service for the medical visit/significant procedure as well as all dates of service for the associated lab/radiology ancillary procedures provided the patient.
- This includes:
  - Lab/radiology services provided by the D&TC.
  - Lab/radiology services referred to outside ancillary providers.
  - Lab/radiology services performed on the same day or subsequent to the D&TC clinic visit.

APG Rate Code 1407 (cont.)

- Multiple visits and associated ancillaries for the same recipient may be reported on the same claim.
- Beginning August 27th the duplicate claim edit will be based on the “from” date in the header.
  - If two claims are submitted by the same APG provider for the same patient using the same visit rate code and the same “from” date for the episode of care, only the first claim will be reimbursed.

D&TCs APG Episode Payment
APG Rate Code 1422

- The date of service for the medical visit/significant procedure will be the date when the patient is seen in the clinic.
- The date of service for all lab/radiology ancillary services should be the date when those services were actually provided to the patient.
  - Lab date of service should be the date of specimen collection.
  - Radiology date of service should be the date when the radiology procedure was provided to the patient.
  - This includes:
    - Lab/radiology services provided by the D&TC.
    - Lab/radiology services referred to outside ancillary providers.
    - Lab/radiology services performed on same day and subsequent to the clinic visit.
- The “from/through” date in the header should encompass the dates of service for the medical visit/significant procedure as well as all dates of service for the associated lab/radiology ancillary procedures provided the patient.

Rate Code 1422 (cont.)

- Only a single episode (e.g., medical visit and associated ancillaries) may be coded on a claim.
- If procedures from two different episodes of care are coded on the same claim, unwarranted discounting or consolidation could occur, resulting in underpayment to the APG biller.
- As with the visit payment, if two claims are submitted by the same APG provider for the same patient using the same episode rate code and the same “from” date for the episode of care, only the first claim will be reimbursed.

APG Visit Payment and Assignment of Ancillary DOS

1407 APG Rate Code

Claim	Date of Service (Line Level)	Service	Ancillary Service Provided	From/Thru Date (Header)
1	1/1/2009	E&M	Yes (See next row)	1/1 - 1/5
1	1/1/2009*	Ancillary	Provided on 1/5*	1/1 - 1/5
1	1/2/2009	Dental	No	1/1 - 1/5
1	1/3/2009	Physical Therapy	No	1/1 - 1/5

* Reassign ancillary to 1/1/2009 DOS on APG claim.

Note: Multiple DOS can be billed for same recipient/same DOS under APG rate code 1407.

APG Episode Payment and Assignment of Ancillary DOS (cont.)

1422 APG Rate Code

Claim	Date of Service (Line Level)	Service	Ancillary Service Provided	From/Thru Date (Header)
1	1/1/2009	E&M	Yes (See next row)	1/1 - 1/5
1	1/5/2009*	Ancillary	Provided on 1/5*	1/1 - 1/5
2	1/2/2009	Dental	No	1/2 - 1/2
3	1/3/2009	Physical Therapy	No	1/3 - 1/3

*Use actual 1/5/2009 DOS on APG claim.

Note: A separate claim must be submitted for each separate DOS for same recipient/same DOS billed under APG rate code 1422.

Claim Submissions for D&TCs

- Two billing options available;
  - Submit the APG claim (medical visit/significant procedure with ancillaries) upon confirmation that all ancillary services have been provided to the patient.
    - Must be submitted within 90 days of the date of service.
    - This is the preferred billing method.
  - Submit the APG claim for the medical visit/significant procedure only.
    - Must be submitted within 90 days of the date of service.
    - After confirmation that all ordered ancillary services have been provided the clinic may submit a claim adjustment that reports the office visit/significant procedure and all completed ancillary tests.
    - If a claim for the medical visit/significant procedure has already been submitted without the lab/radiology ancillary services, an adjusted claim should be submitted for the lab/radiology ancillary service within 30 days of receipt of the ancillary results.
- If the ancillaries are provided more than 90 days after the clinic visit, then the clinic should submit an adjusted claim to report the ancillaries.
- A 90 day letter is not needed for claim adjustments.

Special Payment Policy

Medicare and Commercial Insurance

- For Medicaid recipients who are also covered by Medicare or commercial insurance:
  - If the lab or radiology provider is required to bill Medicare or the commercial insurance directly, the lab/radiology provider should do so.
  - The lab/radiology provider should then bill Medicaid for the balance due.
  - If Medicare or the commercial insurance denies payment for the laboratory test, the laboratory should bill Medicaid fee-for-service by the lab/radiology provider.
  - The clinic should not report these ancillary lab/radiology services on their APG claim.

Ambulatory Surgery Services

- The ambulatory surgery procedures list includes those HCPCS codes which may be billed against the ambulatory surgery base rate if the provider has an APG ambulatory surgery rate code (1408).
  - *The ambulatory surgery procedures list does not mandate the setting in which a procedure may be performed. However, if a visit includes an ambulatory surgery procedure HCPCS code from this list, and the provider has an APG ambulatory surgery rate code, the APG ambulatory surgery rate code should be used on the claim.*
- The following link directs you to the ambulatory surgery list on the DOH website. http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/ambulatory_surgery_list.pdf

Inpatient Only Services

- Under APG payment rules, certain surgical procedures may only be performed in the hospital inpatient setting. These procedures may not be performed on an ambulatory surgery or clinic outpatient basis.
  - *These designated 'inpatient only' procedures will not be reimbursed under the APG payment methodology.*
- They will continue to be paid through the Diagnosis Related Groups (DRG) payment methodology.
  - *The APG Grouper will automatically reject these procedures for payment.*
- The list of these procedures is available at the Department's Web site, please visit: www.nyhealth.gov/health_care/medicaid/rates/apg/docs/inpatient_only.pdf

“Never Pay” APGs

- “Never Pay” APGs are those services that are not covered by NY Medicaid or not covered as a stand alone service or which are carved out of APGs and are therefore not reimbursed under APGs.

- Examples include:
  - *Respiratory Therapy*
  - *Nutrition Counseling*
  - *Biofeedback*
  - *Chemo Drugs*
  - *Artificial Fertilization*

Pathology Professional Component

- Medicaid does not reimburse separately for the anatomical pathology professional component.
- Therefore, the laboratory must reimburse the pathologist for the professional component of the service out of the proceeds received from the ordering hospital or clinic.

Payment for services provided by RNs and LPNs

- Patient encounters with only a RN or LPN (when performed within their scope of service) are billable to Medicaid in a clinic setting in the following specific circumstances:
  - Chemotherapy or other infusion
  - Immunization/Vaccination
  - Therapeutic Injectables (e.g., Depo Provera, Gardisil)
  - Urine pregnancy test
- Requires patient specific order.
- Clinic can't bill E&M if the patient sees only an RN/LPN.
  - *Immunization/vaccination, therapeutic injectable, urine pregnancy test should be billed using the ordered ambulatory fee schedule under COS 0162/0163.*

Payment for services provided by RNs and LPNs (cont.)

- RNs and LPNs may provide service only within their respective scope of practice as defined by the State Education Department laws, rules and regulations.
  - e.g., an LPN may not perform a patient assessment.
- Providers may obtain specific information about practitioner scope of practice at the SED Office of the professions website at http://www.op.nysed.gov/nurse.htm

HIV/AIDS Rate Code Carve-Outs

- The following rate codes will not be subsumed under the APG payment structure. They will continue to be billable under the existing 5-tier or 7-tier rate.
- Hosp OPD & D&TC
  - 2983 / 1695 – HIV Counseling and Testing Visit
  - 3111 / 1802 – Post-Test HIV Counseling Visit (Positive Result)
  - 2961 – AIDS Therapeutic Visit (DAC Only)
  - 3109 – HIV Counseling Visit (No Testing)
  - 1850 – Day Health Care Service (HIV)
- Lab tests not included in these rate-based payments may be billed to Medicaid using the laboratory ordered ambulatory fee schedule.

Utilization Thresholds and Laboratory/Radiology Ancillary Services

- Utilization threshold limits do not apply to laboratory or radiology services that are reimbursed through APGs.

FQHCs

- Ancillary lab/radiology APG billing and payment policy applies to FQHCs that have opted into APGs.
- If an FQHC has not opted into APGs and continues to be reimbursed under the prospective payment system (PPS):
  - In general, lab is carved out of the PPS rate and may be billed to Medicaid by the testing lab using the laboratory fee schedule.
  - Radiology provided on-site at the FQHC is included in the PPS rate, other than MRI which is carved out and may be billed to Medicaid fee-for-service.
  - Services provided to patients referred off-site to a radiology provider may be billed by the radiology provider using the ordered ambulatory radiology fee schedule.

Ancillary Services
Compliance and Enforcement

- OHIP will assist in the APG transition by providing D&TCs and ancillary providers with an analysis of claims for laboratory and radiology services billed to Medicaid.
- 90 days following the D&TC APG implementation date, OHIP will identify lab/radiology procedures that were billed to Medicaid that may, in fact, have been the fiscal responsibility of the D&TC.
- Lab/radiology providers and the D&TC will be given 60 days to reconcile ancillary billings.
- If the ancillary lab/radiology procedures were ordered by the D&TC practitioner for their patient, then the laboratory/radiology provider will need to void their Medicaid claim and bill the clinic.
- OHIP will then do a data query to determine if the ancillary lab/radiology claims have been voided.
- If not, notice will be sent to the ancillary service providers and the D&TC identifying claims that need to be corrected and a copy will be sent to the OMIG.

Supporting Materials & Contact Information

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*