

# Q&As

## June 21, 2010 D&TC Webinar

### GENERAL QUESTIONS

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**Q. What APG training is available?**

- A. APG implementation information is available online at: [nyhealth.gov/health\\_care/medicaid/rates/apg/index.htm#implementation\\_materials](http://nyhealth.gov/health_care/medicaid/rates/apg/index.htm#implementation_materials).  
The next APG Webinar presentation targeted to Diagnostic and Treatment Centers (D&TCs) will be on July 27<sup>th</sup> from 10:00 am to 12:00 pm – details will be provided shortly on the APG website. Providers may e-mail APG questions to: [apg@health.state.ny.us](mailto:apg@health.state.ny.us).

**Q. Will FQHC facilities be mandated to use the APG payment methodology?**

- A. FQHCs will have the option to participate in the APG payment methodology. If an FQHC opts into APGs they will be held harmless from any potential payment decrease because the FQHC wrap payment will make up the difference.

**Q. When will APGs be implemented for Article 16, 31, and 32 providers?**

- A. It is anticipated that the Office of Mental Health facilities (Article 31) and The Office of Alcoholism and Substance Abuse Services facilities (Article 32), including MMTP programs, will implement APGs on October 1, 2010. The Office of Mental Retardation and Substance Abuse (Article 16) facilities will implement APGs on January 1, 2011.

**Q. Are DT&Cs mandated to implement the APG payment methodology?**

- A. Yes, all D&TCs are mandated to implement APGs (other than D&TCs that are FQHCs, who may notify the Department of their intent to opt into APGs by November 1, 2010).

**Q. Can we bill for smoking cessation counseling?**

- A. For APG billers, beginning January 1, 2010, Medicaid will cover smoking cessation counseling during a medical visit to pregnant and postpartum women and children and adolescents ages 10 to 21.

**Q. Will rate code 1435 for MR/DD/TBI be recognized in APG processing? If not, how can we get paid for the MR/DD/TBI enhanced rate?**

- A. Yes, rate code 1435 which is used for D&TC general clinic visits provided to MR/DD/TBI patients is recognized and denotes an APG claim that is eligible for an enhanced MR/DD/TBI base rate. This will be in effect for dates of service on or after September 1, 2009.

**Q. The APG manual has links for those rate codes that have been subsumed. Is there a listing of all outpatient rate codes that have not subsumed by the APGs?**

- A. The full list of all rate codes that have been subsumed by APGs and those which are still in use are available online at: [http://nyhealth.gov/health\\_care/medicaid/rates/apg/docs/apg\\_dtc\\_rate\\_codes.pdf](http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_dtc_rate_codes.pdf).

**Q. The APG rate codes can be billed as of 07/15/10. Is that the date of service? Should claims submitted with a DOS prior to the 7/15/10 date utilize the old rate code?**

**A.** Beginning 7/15/2010, D&TCs will be able to submit their claims with dates of service retroactive to 9/1/2009 using the APG rate codes.

## **FEDERALLY QUALIFIED HEALTH CENTER (FQHC)**

**Q. Can an FQHC opt into APGs now and get retro payments to September 1, 2009?**

**A.** As an FQHC, unless you have already opted into APGs, you will not be able to be an APG biller until January 1, 2011 (you must notify the Department by November 1, 2010 of your intent to opt into APGs).

**Q. Is an FQHC that does not opt in to APGs eligible for the Primary Care Medical Home add-on?**

**A.** Yes, an FQHC not participating in APGs will be eligible for medical home status and payment if they meet the NCQA criteria.

## **RETRO CLAIMS**

**Q. When will the automated reprocessing of the claims begin and how will we know it started with our claims?**

**A.** Claims auto-reprocessing by eMedNY will begin on August 1, 2010, however, providers can begin reprocessing their own claims manually using APG access rate codes beginning on July 15, 2010. Providers should resubmit all APG claims as adjustments to the original claims to avoid claims being rejected under the duplicate claims restrictions.

**Q. If we choose to manually adjust our claims for the retroactive amount, does the adjustment get done over two payment cycles (one to cancel the original claims and the next cycle for the new information) or all in one cycle?**

**A.** If the necessary adjustment will result in additional payment being owed to the provider, it will occur over one cycle. If an adjustment is done which requires money to be recovered from the provider, this may be done over multiple cycles depending on the amount of the overpayment.

**Q. Is the August 1 reprocessing cut-off date the claims submission date or date of service?**

**A.** It is the submission date.

**Q. For manually reprocessed claims, should the D&TC submit these as claim adjustments or should the original claim be voided and a new APG claim submitted?**

**A.** Providers should resubmit their claims as adjustments to their existing claims.

- Q. If a D&TC has clinic rate claims still open for dates of service prior to September 1, 2009, will these be reimbursed at the clinic threshold rate or the APG rate?**
- A. Services provided prior to the September 1, 2009 APG implementation date will be paid at the clinic threshold rate.
- Q. Can a D&TC resubmit old claims that didn't have CPT codes on them?**
- A. Yes, the APG payment methodology requires procedures (e.g., CPT codes) and diagnosis (i.e., ICD-9 code) to be included on the claim to calculate payment. You may make adjustments to claims to add additional appropriate CPT codes - such as for the after hours access payment.
- Q. What rate code do we use to process a claim with a service date prior to September 1, 2009, when the old rate codes are end dated?**
- A. For dates of service prior to September 1, 2009, providers may still use old rate codes in effect before APG implementation. On December 1, 2010, the Department of Health will end-date the current D&TC and ambulatory surgery center rate codes to be subsumed by APGs.
- Q. If a claim was submitted for dates of service between September 1, 2009, and July 15, 2010, and the primary diagnosis was incorrect, should the original claim be voided and a new APG claim submitted or can a provider adjust the previously submitted claim with a new primary diagnosis code?**
- A. Providers can submit an adjusted claim without voiding the initial claim.
- Q. While the claims are being reprocessed retroactively, how do we avoid duplicate submissions if a clinic decides to manually reprocess their claims?**
- A. If you have already reprocessed the claim, DOH will not do so. If by some chance DOH reprocesses a claim that you have already submitted as an adjustment, then the DOH claim will edit out as a duplicate claim and it will not affect your manually submitted claim.
- Q. When eMedNY reprocesses claims for dates of service September 1, 2009 thru July 15, 2010, is there logic to account for previously submitted claims that include ancillary services?**
- A. D&TCs were previously instructed that the ancillary policy (i.e., contracting with ancillary vendors) was to be implemented prospectively upon CMS approval and they were not to code ancillaries on their APG claims that were performed by laboratories/radiology providers not affiliated with the D&TC unless those ancillaries were historically included in the D&TC's clinic threshold rate (viz., PCAP ancillaries). If you have ancillaries coded on an APG claim that are being billed to Medicaid by an ancillary vendor you will be subject to OMIG action if you do not revise you claim and remove those ancillaries. All ancillary procedures included on all claims during the reprocessing period (9/1/2009-7/31/2010) will be paid as if all procedures including ancillaries were performed by the D&TC billing provider or as if the D&TC had a contract with the ancillary vendor and the vendor was not billing Medicaid directly. **Note:** DOH is now delaying and revising the ancillary policy. Therefore, ancillaries that have historically been sent

out by the clinic and billed to Medicaid by the ancillary provider should continue to NOT be coded on the APG claim until further notice.

## **MODIFIERS**

### **Q. Have APG modifiers been activated?**

A. All but modifiers 25 and 27 are active.

## **DIAGNOSIS CODING**

### **Q. How will 3 primary diagnosis e.g. diabetes, HTN, depression be billed?**

A. The principal diagnosis is always going to be the basis for the medical visit APGs unless certain severe acute conditions (e.g., 00321 Salmonella Meningitis, 0065 Amebic brain abscess, 06640 West Nile Fever) appear in one of the first 6 diagnoses positions (i.e., principle diagnosis, admitting diagnosis, first 4 secondary diagnoses) in which case the Evaluation and Management service will be assigned to APG 510 - Major Signs and Symptoms and Findings.

### **Q. How many diagnosis codes can be submitted on an APG claim?**

A. Up to 16 diagnoses will be accepted by the APG Grouper Pricer, but only the first six will be used to map to an APG.

## **RATES**

### **Q. What time period is considered the new base year?**

A. The initial base rate for D&TCs will be in effect from September 1, 2009, through November 30, 2009. In the initial phase, 25% of the payment will be based on APGS and 75% will be based on the facility's average calendar year 2007 existing operating payment. For Jan 2010, the base period will change to December 1, 2008 to September 30, 2009. For July 2010, the base year will be CY 2009.

### **Q. How are base rates recalculated?**

A. Base rates are recalculated by adding the investment to the base year payments and dividing that by the CMI (average for peer group) multiplied by base year visits. Generally, base rates are recalculated whenever APG weights are updated.

### **Q. How was the value for the capital add-on payment calculated?**

A. The add-on component is calculated based on the facility specific capital cost per visit not including an additional recruitment and retention component. This calculation has not changed under APGs. However, if you formerly used multiple rate codes, the capital from those rate codes has been rolled up on a weighted average basis into a single capital add-on for use in APGs.

**Q. Is DOH going to reimburse other services under APGs in the future?**

A. Mental hygiene services will be moving to APG reimbursement later in 2010 or early in 2011. Additionally, the ordered ambulatory fee schedule could be eliminated and all ordered ambulatory services may be reimbursed under the APG methodology in the relatively near future.

**Q. Is there any way to find out our new base rates prior to June 30, 2010?**

A. On July 1, 2010, DTC providers were notified via e-mail of their payment rates including base rates, existing payments for blend, capital, CMLs etc. Please let us know if you did not receive this e-mail and will make certain to send it to you.

**Q. Has the current cost of ancillaries been added into the base rate?**

A. The current base rates include the cost of ancillary tests and procedures for providers that have ancillary dollars included in their current D&TC rate (such as PCAP providers). Otherwise, the cost of ancillaries has been excluded from the revised APG rates transmitted on July 1.

**Q. When will D&TCs be required to use the APG episode rate code?**

A. D&TC providers should use the visit rate code for dates of service September 1, 2009, through December 31, 2010. The episode rate code has not been activated for D&TCs, but will be shortly. Providers will be notified when this occurs. The Department plans on requiring that all clinic providers convert to the APG episode rate code on January 1, 2011, and no longer use the APG visit rate code. CPT 90862 groups to APG 426, which is a "no blend" APG.

**Q. Does this mean that payment for this procedure is made at the 100% APG calculated amount with no blend?**

A. Effective April 1, 2010, the Department implemented a number of "no blend" procedures (e.g., CPTs H0023 Alcohol and/or Drug Outreach, H0038 Self-help/peer services par 15 min, and V5010 Assessment for hearing aide) and "no blend" APGs (e.g., APGs 321 Crisis Intervention, 414 Level I Immunization and Allergy Immunotherapy, and 426 Medication Management). These services are reimbursed at the full APG calculated amount. A full list of "no blend" procedures is available for viewing at:

[http://nyhealth.gov/health\\_care/medicaid/rates/apg/docs/apg\\_no\\_blend\\_procedures.pdf](http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_blend_procedures.pdf)

**Q. What is the capital add-on payment and how is it calculated for each patient visit?**

A. Except for ambulatory surgery centers, the capital add-on is a facility-specific component of the APG visit payment that is based on the average capital cost per visit. The capital add-on for ambulatory surgery centers is an average capital amount facilities are currently receiving as a peer group by region.

**Q. Is it possible that clinics can experience reduced reimbursement rates under the new system?**

A. Generally, clinics should be positively impacted by converting to the new APG payment methodology because the investment (a total of \$50 million fully annualized) is included in the base rate. However, it is possible for a facility to be paid less under the new methodology if, for example, a facility has a high threshold rate and renders predominantly low intensity procedures.

**Q. During 8/09 we were notified as to what our APG rates will be, including the blended rates during the 4 year phase-in. Have these APG base rates significantly changed since August 2009?**

A. The most recently disseminated base rates which D&TC providers received July 2010 via e-mail are higher than those previously distributed and the blend amount has, generally, dropped, since ancillaries are now excluded from the blend due to the delay and revision to the ancillary contracting policy

## **DENTAL**

**Q. Will dental visits at a D&TC when done with another visit be paid at 100% rather than a reduced rate.**

A. All dental APGs do not package with medical visits (except for APG 563). Therefore, both the dental service and the medical visit will both pay at 100% if provided on the same DOS.

**Q. Is there a frequency limit in APGs for dental prophylaxis provided to developmentally disabled patients?**

A. There are no dental frequency edits applied to dental services in APGs.

**Q. For ambulatory dental surgery, if commercial insurance is primary, can a dentist bill fee for service for professional services?**

A. The dental professional component is included in the APG payment to the D&TC. A separate claim cannot be billed to Medicaid by the dentist.

**Q. Will a dental procedure of D2750 (crown) on the same tooth in several visits be paid-in-full on each visit?**

A. If a procedure requires three encounters to complete, a clinic should claim for the applicable dental procedure code for each distinct date of service.

**Q. For dental schools what code do we use for after hours?**

A. On the APG claim, DOH is allowing the use of two codes for this, neither of which is a dental code – 99050 and 99051. You should also code all applicable D codes. More information on after hours access payments can be found in the APG Provider Manual – section 6.2

**Q. Will School Based Dental Clinics be using APGs with the effective date of D&TCs?**

A. Yes, school Based Health Center D&TCs should use APG rate code 1447 for both managed care and non-managed care enrollees upon APG implementation. Under threshold payment all services were billed with a dental V code in the diagnosis section of the claims. Providers may continue to use dental V codes to bill for dental visits as long as they are valid ICD-9 codes.

**Q. Is a Dental clinic required to use APGs or is it a carved-out service?**

A. Dental clinics will be treated exactly like other free-standing D&TCs and will be required to convert to the new APG payment methodology effective September 1, 2009.

**Q. Can article 28 dental clinics receive the additional payments and enhancements for evening/weekends and for developmentally disabled patients?**

A. Dental clinics will be converted to the new APG payment methodology just like all other free-standing D&TCs and will be able to bill for appropriately designated MR/DD/TBI patients using the enhanced base rates. They may also use 99050 and 99051 on their APG claim for the after hours payment. Those are the only non-D code procedure codes they may use.

**Episode Rate Code**

**Q. When can D&TCs begin to use the Episode rate code?**

A. As of July 15 2010, D&TC can begin billing APG using the visit rate code 1407. Episode rate codes will be available at a later date. Guidance will be issued prior to that time.

**Multiple Same Day Services**

**Q. Since D&TCs will have to begin billing under APGs by December 1, 2010, how will the “existing payment” and APG blend work?**

A. Providers should begin using the APG rates codes beginning July 15, 2010. The eMedNY system will automatically reprocess claims submitted with the old rate codes going back to 9/1/2009. Effective December 1, 2010, the old rate codes will be zeroed out and will no longer be in use. APGs will be phased-in as follows (based on date of service):

- *9/1/2009 - 11/30/2009 – Phase I (25% of payment will be based on APGs, 75% based on the existing operating rate for 2007, the capital add-on will be added to that amount)*
- *12/1/2009 – 12/31/2010 - Phase II (50% of payment will be based on APGs)*
- *1/1/2011 – 12/31/2011 – Phase III (75% of payment will be based on APGs)*
- *1/1/2012 forward – Phase IV (100% of payment will be based on APGs)*

**Q. Can different specialists see a Medicaid patient on the same day and bill?**

**A.** Different specialists may see patients on the same day, and all services and procedures performed on that day should be billed for on the claim. The APG grouper/pricer will apply the APG grouping logic to all services and procedures with the same date of service. When more than one E/M visit is performed on the same day, only one visit will be reimbursed under APGs. The other visits will consolidate and pay \$0. Providers should report modifier “27”, additional medical visit, for the second E&M, although at present modifier 27 has no effect on payment.

**Q. When there are multiple services by different providers on the same day, should the CPT codes be presented in any particular order? For example, what will happen when podiatry services show up under the NPI of a dentist, because the dental line item is first on the claim?**

**A.** The CPT codes may be reported in any order. The NPI of the practitioner who provided the major or most significant procedure should be reported on the APG claim. The eMedNY system checks the validity of the servicing provider listed on the claim to insure that they are licensed, but does not cross-edit the provider with the CPT codes reported on the claim.

**DIALYSIS**

**Q. Should dialysis clinics report all laboratory and radiology procedures on their APG claim?**

**A.** Yes, effective January 1, 2011, all D&TCs must include all lab/radiology ancillary services on their APG claim – both those that they themselves provide the patient as well as those that are sent to a reference laboratory or other radiology provider not affiliated with the dialysis clinic. Prior to January 1, 2011, D&TCs should only code the ancillaries that they, themselves, actually perform.

**Q. For dialysis centers, in addition to the drug, Epogen, is Aranesp also carved-out of the APGs?**

**A.** Yes. Aranesp (Darbeopoetin Alfa), like Epogen (Epoetin Alfa), is carved-out of APGs for dialysis centers. The drug should be billed fee-for-service to Medicaid using the ordered ambulatory fee schedule.

**Q. Will the physician professional component remain carved-out of the dialysis clinic rate?**

**A.** Yes. The physician professional component remains carved-out of the dialysis APG payment.



- Q. Do we need to include on the APG claim the CPT codes for routine monthly labs that are drawn in the dialysis facility and sent to an outside contracted lab?**
- A. Effective January 1, 2011, D&TCs must include the CPT codes for all lab/radiology ancillary services on their APG claim, whether performed by the D&TC or referred to an outside lab/radiology provider. Prior to 1/1/2011, D&TCs should code only the ancillaries that they themselves actually perform.
- Q. As a renal clinic, we are billing clinic fees only, and the physician is billing for his services. If the physician orders labs, would he not be responsible for billing the ancillaries on his claim?**
- A. No. Physicians providing services in dialysis clinics can bill Medicaid for their professional services only. All laboratory tests ordered for a dialysis patient are the responsibility of the dialysis clinic but will not need to be coded on the clinic claim until January 2011 – unless provided in-house.
- Q. We operate four dialysis clinics in Westchester County. Two of the clinics have a rate that is different from the other two clinics. Will the APG reimbursement methodology eliminate the payment differential?**
- A. If you were given only a single blend amount and a single capital amount, then the payment differential (for identical coding) will be eliminated under APGs. If you were given two or more blend amounts, then in our system you looked like multiple providers and the payment differential would not be eliminated until Jan 2012 when APGs are fully implemented.

### **MEDICARE AND OTHER THIRD PARTY**

- Q. If the client has Medicare as primary insurance should we report lab tests on our APG claim?**
- A. For Medicaid recipients who are also covered by Medicare the lab provider should bill Medicare. The lab claim will be crossed over to Medicaid automatically by Medicare for payment of appropriate co-insurance and deductibles. If Medicare denies payment for the lab test, the lab should bill Medicaid fee-for-service and zero fill the Medicare paid field. The clinic should not report these lab services on their APG claim. The same policy applies to patients who have commercial insurance and Medicaid. Unlike Medicare, the commercial insurance payer will not crossover the claim to Medicaid. The commercial insurance will pay the lab, which will then need to submit a separate claim to Medicaid for the balance.

**Q. If a patient has Medicare and Medicare does not cover a particular service, what is the policy for billing that service to Medicaid under APGs?**

**A.** For Medicare/Medicaid crossover patients, Medicaid generally defers to the Medicare payment decision, e.g., if Medicare denies payment because the service is determined to not be medically necessary, Medicaid cannot pay for that service.

**Q. How will APG claims be processed for Medicare/MA dually eligible recipients?**

**A.** Medicaid will continue to pay the full annual Medicare Part B deductible as well as the full 20% Medicare Part B coinsurance amounts for all APG Medicare/Medicaid “crossover” claims. D&TCs that provide services to Medicare/Medicaid dually eligible recipients that have been assigned Recipient Exception Code 95 (MR/DD recipients are assigned this code, which is displayed when the provider verifies recipient eligibility) should bill APG rate code 1435 (Visit) or 1425 (Episode) and will be paid the difference between the Medicare paid amount and the calculated APG payment. Claims for dually eligible patients with Recipient Exception Code 95 should first be submitted to Medicare for claims processing. The claim will be crossed over automatically to Medicaid, who will then pay the full Medicare deductible and/or crossover amounts. The D&TC will then need to submit a claim adjustment to Medicaid to receive payment up to the calculated APG rate.

## **OUT OF STATE**

**Q. Is there an Upstate and Downstate APG rate for “out of state” providers?**

**A.** Rates of payment for out-of-state providers in counties contiguous to New York City, Dutchess, Putnam, Westchester, Rockland and Orange Counties reflect the average APG payment for the same services applicable to New York State providers in those areas. Those out-of-state counties contiguous to the downstate region include: Union, Sussex, Passaic, Bergen, Hudson, Essex, Middlesex and Monmouth counties in New Jersey; Pike County in Pennsylvania, and Fairfield and Litchfield Counties in Connecticut. Rates of payment for all other out-of-state providers reflect the average APG payment applicable to New York State providers throughout the rest of the state (i.e. “upstate”).

## **ANCILLARY POLICY**

**Q. Is there a list of ancillary reimbursement rates, e.g., how much a facility will be paid for an HIV RNA PCR?**

**A.** A list of reimbursement rates for ancillary services is not available. D&TCs can calculate the expected APG payment for ancillary lab tests by identifying the APG group that the lab test groups to, the weight for that APG group, and multiplying the base rate by that APG weight. Final payment will be dependent upon whether or not the service provided is packaged or consolidated by the grouper payment logic.

**Q. Can an Article 28 D&TC contract with a lab and not a radiology facility or vice-versa? Or if the Article 28 facility contracts with one must you contract with the other?**

**A.** Effective January 1, 2011, D&TCs will have the option of:

- ***contracting with a lab and/or radiology provider and paying that provider directly for diagnostic tests ordered for their patients, or,***
- ***directing lab/radiology providers to bill Medicaid directly for all diagnostic tests ordered for their patients.***

With either option, the D&TC will be required to report all ordered lab/radiology procedures on their APG claim. However, this policy is still in “draft” format and is subject to revision. If the D&TC contracts with an ancillary provider, Medicaid will reimburse the D&TC for lab/radiology procedures through APGs. If the D&TC does not have a contract with the ancillary provider, Medicaid will deduct the cost of packaged ancillaries from the provider’s APG payment (since the cost of such ancillaries is already reflected in the E&M/significant procedure also being reported on the APG claim). For non-packaged ancillaries, the D&TC will be reimbursed \$0, since the lab/radiology provider has submitted a claim directly to Medicaid. A D&TC may choose to contract for lab and/or radiology. They will not be required to contract for both types of ancillaries. Billing instructions for identifying if a diagnostic test reported on an APG claim by a D&TC was provided by a contracted or non-contracted provider are being finalized. We expect that D&TCs will have to identify, on the APG claim, any non-contracted ancillaries (i.e., those that will be billed directly to MA by the ancillary vendor) with a specific CPT code modifier (probably “90”).

**Q. Does the APG claim need to include the exact CPT code of MRI or scan ordered for the patient?**

**A.** Yes, the CPT-4 procedure code reported on the APG claim must reflect the actual service

**Q. If a D&TC contracts with an ancillary services provider, should they report the ancillary services on their APG claim when those tests have been ordered, or should they wait until the test results have been reported and then report the ancillaries on their APG claim?**

**A.** If a D&TC contracts with an ancillary services provider, two billing options are available:

- 1. Submit the APG claim (medical visit/significant procedure with ancillaries) upon confirmation that all ancillary services have been provided to the patient. This is the preferred billing method.***
- 2. Submit the APG claim for the medical visit/significant procedure only. After confirmation that all ordered ancillary lab/radiology services have been provided the patient, the D&TC may submit a claim adjustment that reports the office visit/significant procedure and all completed ancillary tests. The rule mandating that claims must be submitted within 90 days of the date of service does not apply to claim adjustments. However, the claim adjustment must be submitted within 30 days of the date the claim came under the control of the D&TC.***

**Q. If we draw blood at our facility and then send it to a lab for processing, will that be treated differently from sending the patient to the lab for the entire process?**

**A.** Whether the blood specimen is taken at the D&TC or the patient is sent to the lab collecting station is immaterial. If the clinic physician orders lab tests, those tests must be reported on the D&TCs APG claim. On a radiology referral where there is no contract, does the rate get reduced based on the referral even if the patient does not keep the referral appointment.

The ancillary policy has been delayed for freestanding D&TC providers until January 1, 2011. Post January 1, 2011, D&TCs must include all lab/radiology ancillary services that result from a D&TC clinic visit (either provided or ordered); the ancillary services are to be included on the claim after the clinic provider has received confirmation that the ancillary test was performed. If the D&TC clinic does not contract with the ancillary vendor, the clinic provider must still include the ancillary service on the claim along with a modifier (probably modifier 90) that will allow the ancillary provider to bill Medicaid directly.

It is important that the D&TC not report ancillary services on their APG claim until they receive confirmation (e.g., test results) that the ancillary services have been provided to the patient. The costs associated with non-contracted packaged ancillaries will be deducted from the D&TC's APG payment. If those packaged ancillaries have not been provided to the patient, the clinic will in effect be covering the costs of tests that were never actually delivered.

**Q. If you contract with a laboratory for labs, but not with a radiology provider, should you put the radiology on the claim with a modifier 90?**

**A.** After January 1, 2011, the Article 28 D&TC is required to enter a modifier 90 on the radiology claim if there is no contract with the ancillary vendor providing the service. The 90 modifier will indicate that the clinic should not be paid for the ancillary service and that a separate claim will be submitted by the ancillary provider.

**Q. HPV testing is automatically done by lab dependent on pap results after we've submitted the claim to Medicaid. The same is true for gonorrhea tests done reflexively for a positive Chlamydia test. How would we submit the claim for these tests?**

**A.** Effective January 1, 2011, D&TCs must include all lab/radiology ancillary services on their APG claim. If a lab test is performed subsequent to the initially ordered tests and the D&TC has already submitted an APG claim, the D&TC should submit a claim adjustment to report the additional lab tests provided the patient. If that test is to be billed by the ancillary provider, the procedure code on the APG claim must also have modifier 90 attached.

**Q. Is genetic testing carved-out of the APG payment to the D&TC?**

A. Yes. All genetic testing procedures are carved-out of APGs and are billable to Medicaid fee-for-service by the testing lab.

**Q. Diabetes patients come to the D&TC one week prior to their scheduled clinic visit for a blood draw. How should this be billed to Medicaid?**

A. Laboratory tests provided to a patient should not be reported on a clinic APG claim subsequent to when the blood specimen was collected, but should instead be reported on the prior clinic APG claim that was submitted to Medicaid for the patient. This may require that the D&TC submit a claims adjustment for the previously paid claim.

**RN/LPN**

**Q. When a RN gives an allergy shot, is this billable as an episode or procedure?**

A. The allergy shot is billable to APGs when the patient only sees an RN. However, an E&M code cannot also be billed (in addition to the allergy shot and administration codes) if the patient has seen an RN only and not a higher level practitioner such as a physician, physician assistant, or nurse practitioner.

**Q. The webinar stated that immunizations/vaccinations including Gardasil and allergy shots are billable when administered by RN or LPN. Are all immunizations to prevent disease such as MMR, DPT, etc. billable under APGs?**

A. Yes, all immunizations (except flu, H1N1, and pneumococcal, which are APG carve outs and billed to ordered ambulatory) are billable when administered by RNs or LPNs within their scope of practice. However, an E&M visit code cannot be billed if the patient has seen an RN only and not a higher level practitioner such as a physician, physician assistant, or nurse practitioner. Immunizations are currently being billed fee-for-service.

**Q. Why is that changing under APGS?**

A. Certain specific immunizations can be billed to Medicaid fee-for service as ordered ambulatory. This includes seasonal flu, H1N1, and pneumococcal immunizations. This policy is not changing under APG implementation.

All other vaccines (except those provided by the Vaccines for Children Program) are reimbursed through APGs when administered in the D&TC setting.

Providers who are administering State-supplied vaccines to Medicaid enrollees under the age of 19 years through the Vaccines for Children program, must bill for the vaccine administration as an ordered ambulatory service (not APGs) using the procedure code for the vaccine, appended with the modifier SL (to indicate a State-supplied vaccine). Providers will be reimbursed a \$17.85 administration fee.

## **PHYSICAL THERAPY**

**Q. We have previously billed all physical therapy services under one CPT code and were reimbursed the full clinic threshold rate. For D&TC claims that were submitted for dates of service on or after September 1, 2009, that have been reprocessed by eMedNY, we will be permitted to adjust those claims to show all physical therapy modality codes?**

**A.** The claims can be resubmitted as adjustments with the specific physical therapy CPT codes. D&TCs should include units associated with the CPT codes, when appropriate, to insure accurate APG payment.

**Q. How would physical therapy be billed if you are not sure how many visits the patient will have and when their physical therapy visits will be scheduled?**

**A.** Visits should only be billed after the service so this should not be an issue.

**Q. Is it possible to bill for more units of PT than the limit for the visit? How would that be billed, i.e. 4 units of PT when the maximum is 3?**

**A.** You will only receive payment for the maximum number of units for that procedure code.

**Q. Are group sessions of physical therapy or speech therapy reimbursed in APGs?**

**A.** Yes. Group physical and speech therapy can be billed under APGs.

## **CSW**

**Q. When will guidance be available for the billing of mental health counseling provided in Article 28 clinics by licensed clinical or licensed master social workers?**

**A.** Billing guidance will be available shortly in the Medicaid Update.

## **SBHC**

**Q. Do rate codes 1447 & 1453 for School Based Health Clinics apply for both medical & dental services?**

**A.** Yes. Medical and/or dental services provided in a School Based Health center should be billed under the 1447 (SBHC APG Visit) or 1453 (SBHC APG Episode) rate codes. Prior to APGs, SBHC services were exempt from utilization threshold (UT) authorization.

**Q. With the implementation of APGs, are SBHC services still exempt from UT service authorization?**

**A.** All services provided by SBHCs continue to be exempt from Utilization Thresholds.

## **HIV**

**Q. If HIV counseling and testing rate codes are carved-out of APGs, how are they billable?**

- A. The existing rate codes for HIV counseling and testing may continue to be billed fee-for-service to Medicaid.

## **NUTRITION SERVICES**

**Q. Nutrition services have not been historically reimbursable. Are they now reimbursable under the APG methodology?**

- A. Nutrition services are not covered as a “stand alone” service. Nutrition services will be reimbursed under APGs when provided during a patient visit where an E&M is also provided and billed.

## **MANAGED CARE**

**Q. Will Medicaid Managed Care plans be required to reimburse under APGs? If a clinic provides services to a Medicaid managed care recipient, will they receive reimbursement calculated on the same base rate?**

- A. The APG payment methodology is not applicable to Medicaid capitation payments to health plans for Medicaid managed care or Family Health Plus enrollees. However, to the extent that Medicaid health plans are statutorily or contractually required to pay providers the Medicaid rate of payment (or a percentage thereof) for certain services provided to plan enrollees (e.g., payment to non-participating providers for emergency services or payment to academic dental centers for dental services), plans will need to determine the appropriate Medicaid payment under APGs.

## **AMBULATORY SURGERY**

**Q. Does the procedure have to be on the State’s Ambulatory Surgery list in order to bill the ambulatory surgery rate code?**

- A. No. Beginning July 1, 2010, if the procedure is performed in the operating room or in the clinic under general or IV sedation, it can be billed using the ambulatory surgery rate code. This only applies to providers certified as free-standing ambulatory surgery centers with the APG ambulatory surgical rate code assigned to them.

**Q. Anesthesia providers presently bill for their own services. Will this still be allowed, or will the anesthesiologist’s payment be included in the APG payment to the facility?**

A. Yes. Anesthesiologists (and surgeons) will continue to bill for their own services.

**Q. Is post-surgical lab testing included in the APG payment to the ambulatory surgery center? Will Medicaid reimburse pathologists directly for specimen examinations?**

A. All post-surgical tests ordered by the D&TC ambulatory surgery unit or ambulatory surgery center practitioner should be billed by the testing laboratory to Medicaid using the laboratory fee schedule. Medicaid payment to the laboratory is global and includes both the technical and professional (e.g., pathologist) components.

**Q. If a patient has services from both an ambulatory surgery center and a D&TC located in the same facility on the same day, can two APG claims be submitted?**

A. Yes, as long as the services are not related.

**Q. How will ambulatory surgery retroactive claims be processed under APGs?**

A. If a provider had billed rate codes 1804 and 1805 for the same recipient, the providers will need to void the "same visit" 1804 & 1805 claims and then resubmit a single APG claim for the visit which includes the CPT codes for both the primary and the secondary procedures performed during the visit. Voiding the 1805 claim and adjusting the rate code on the 1804 claim to 1408 and adding the 1805 claim's CPT codes to the 1408 claim is another option. If providers have not voided (or adjusted) these claims prior to the start of eMedNY's reprocessing of APG claims on August 1, eMedNY will void the same visit 1804/1805 claims at that time and providers may re-bill using the APG rate code.

## **AFTER HOURS**

**Q. How will CSC know if a service was provided after hours when they reprocess the claims? How will they know in the future?**

A. If the CPT code for an after-hour visit was reported on the claim, the claim will be reprocessed and the add-on amount paid. If it was not reported on the claim, you will need to adjust the claim and report the add-on CPT code.

**Q. What time does after-hours start?**

A. An evening visit is one which is scheduled for and occurs after 6:00 p.m.