New York State Department of Health

Ambulatory Patient Groups (APG)

KNOWN ISSUES LIST

As of
June 17, 2010

The Ambulatory Patient Group (APG) Known Issues List is designed to keep providers and other interested parties informed of new issues related to the implementation of the APG payment methodology. The document includes important announcements, new issues, active issues and recently closed issues.

This document will be posted on http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm (SDOH APG Website) and on www.nyhipaadesk.com (Issues of eMedNY) and will be updated as issues are corrected and/or new issues, identified. Please visit these sites periodically for updates. If you do not understand the technical terminology in this document, please consult with your technical staff or email us at: nyhipaadesk@csc.com or at: apg@health.state.ny.us.

ANNOUNCEMENTS

CMS Approval of Implementation of APGs in DTCs

On June 14, 2010 CMS approved the implementation of the Ambulatory Patient Group payment methodology for free standing diagnostic and treatment centers (DTCs) and free-standing ambulatory surgery centers, with an effective date of September 1, 2009. Detailed billing guidance will be sent to affected providers.

APG Provider Manual and Other Implementation Materials Updated

The APG provider Manual and other implementation materials have been updated and may be accessed at the SDOH APG website.

Ancillary Billing Policy Delayed for DTCs until January 1, 2011

The implementation of the ancillary billing policy that requires APG billers to be financially responsible for all ancillary laboratory and radiology services which they order for clinic patients will be delayed until January 1, 2011. Laboratory and radiology services which have historically been referred to an outside laboratory may continue to be billed directly to eMedNY by the ancillary service provider using the Medicaid fee schedule and do not have to be reported on the APG claim. However, any ancillary services provided directly by the DTC clinic or historically included in the threshold payment or specialty rate (e.g. as with former PCAP rates) should be reported on the clinic claim, even those that map to “a never pay APG” or an “if stand alone, do not pay APG.”

New Base Rates and Fiscal Impacts to be Issued Shortly

Due to the delay in implementing the ancillary billing policy, the DTC base rates and each facility's existing operating payment for purposes of the blend are being revised as are our estimates of the overall fiscal impact of APGs on your facility. Each DTC will receive a letter within the next three weeks indicating the new DTC base rates, your facility's operating payment for purposes of the blend, and the SDOH's estimate of the fiscal impact of APGs on your facility from September 1, 2009 through December 31, 2010.

January 1, 2010 Changes to Grouper/Pricer and APG Reimbursement Methodology

The following changes to the APG reimbursement methodology will become effective January 1, 2010.

1. Hospital-based outpatient departments (OPDs) and school based health centers (SBHCs) must use new episode rate codes (1432 and 1450, respectively) to submit claims for most Medicaid patients. However, visit rate codes (1400 and 1444, respectively) may continue to be used by OPDs and SBHCs providers to bill for dual eligible patients.
2. APG weights and base rates have been updated. To see new weights and base rates see the Department's APG website at : http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm#rates
3. Pharmacotherapy and chemotherapy classifications will expand from 5 to 6 levels. However, chemotherapy drugs will continue to be carved out of APGs.
4. A new "premium" drug APG is created consisting of both chemotherapy and pharmacotherapy drugs. This APG and its associated drugs will be carved out of APGs and will be billable to Medicaid based on the ordered ambulatory fee schedule.
5. In addition to those mental hygiene APGs that currently exist, new APGs will be created for:
    a. Physical Therapy – Group
    b. Speech Therapy – Group
    c. Crisis Intervention
    d. Medication Administration and Observation (primarily for MMTP, which will <u>not</u> move to APGs in January 2010)
    e. Mental Hygiene Assessment
    f. Mental Hygiene Screening and Brief Assessment
6. To recognize significant cost differentials within in a single service, some procedures will be paid based on a procedure-specific weight rather than an APG-specific weight. For a list of specific procedures that have been assigned weights see the Department's website at : http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm#rates
7. Units of service will be recognized by the APG grouper-pricer for some physical therapy, occupational therapy, and nutrition procedure codes, as well as crisis management and

patient education, including diabetes and asthma self-management training by certified diabetes and certified asthma educators.

8. Medical visits will no longer package with the more significant ancillaries (e.g. MRIs, mammograms, CAT scans, etc.), dental procedures, physical therapy, occupational therapy, speech, and counseling services. In these cases, a coded medical visit will pay at the line level. All significant ancillaries will become "if stand alone, do not pay" procedures.
9. The multiple same APG discounting (rather than consolidating) feature that currently applies to most dental services will be expanded to include dental sealants, occupational therapy, physical therapy, speech therapy, and most mental hygiene APGs.
10. The 'no capital add-on' rule will change slightly. Formerly, a visit that consisted entirely of ancillaries did not receive a capital add-on payment. In January, capital add-on payments will be paid for nearly all visits except for those visits that consist solely of medication administration, physical therapy-group, speech-group, cardiac rehabilitation, immunization, and patient education. Capital add-ons will be paid for dental exams.
11. A new enhanced MR/DD/TBI base rate will be effective paying an additional 20% for patients with RE code 95 or RE code 81.
12. Genetic testing procedures will be carved out and will be billable to Medicaid as an ordered ambulatory service.
13. The no-blend APG list will be expanded to include cardiac rehabilitation (which comes off the never pay APG list in January), development testing, crisis management, medication administration, and medication management.
14. Reimbursement for physician professional services provided by hospital OPDs will be carved- out of APGs beginning February 1, 2010. This only applies to physicians. There will be no change to current Medicaid policy which disallows payment of interns and/or residents, yet permits payment for supervising and/or teaching physicians under specified conditions.
15. Upon federal approval, the Department will provide incentive payments to providers recognized as patient Centered Medical Homes by the National Committee for Quality Assurance. Medicaid FFS claims with appropriately coded Evaluation and Management codes 99201-99205, 99211-99215 or Preventive Medicine codes 00381-99386, 99391-99395 will be eligible for enhanced payment levels commensurate with their level of NCQA certification.

All PCAP Rate Codes to Be End-Dated

As a result of the passage of Chapter 484 of the Laws of 2009 eliminating the PCAP program, all Prenatal Care Assistance Program (PCAP) rate codes will be end-dated now that CMS approval of the implementation of APGs in DTCs has been received. PCAP rate codes have been subsumed by APGs for most hospital based clinics. The effective date for end-dating PCAP rate

codes for DTCs will be December 1, 2010. Providers that formerly billed PCAP rate codes will then have to bill using appropriate APG rate codes. FQHCs that have opted not to participate in APGs will have to use their PPS rate code to bill for prenatal care services on or after that date. FQHC providers will be notified when the PCAP rate codes are end-dated.

NEW ISSUES

ACTIVE ISSUES

CLOSED ISSUES